Medicaid Program Evaluation

Working Paper

Medicaid Program Evaluation, Cluster II
INPATIENT HOSPITAL REIMBURSEMENT

Selective Contracting in California:
The First Year

MPE Paper 3.1 December 1984

Principal Authors	Contributing Authors
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Department of Health and Human Services
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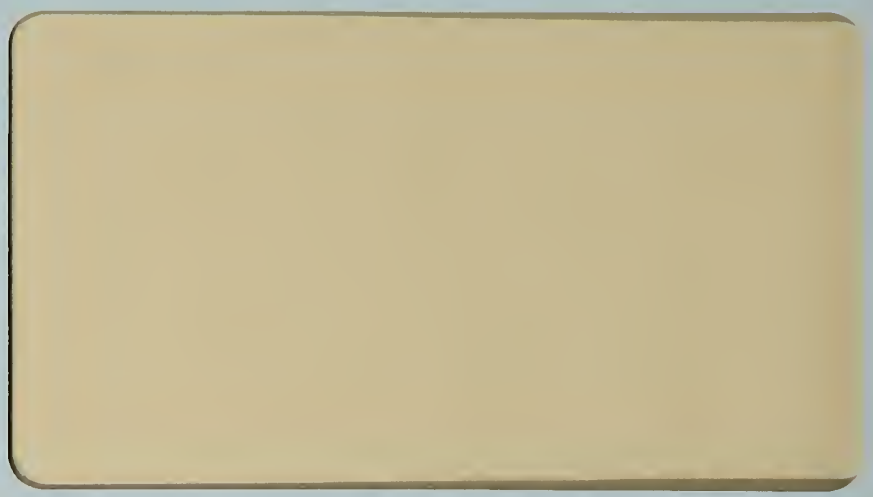

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PREFACE

The Medicaid program, which finances health care for over 20 million needy Americans, has undergone major changes since 1981. Beginning with the Omnibus Budget Reconciliation Act of 1981 (OBRA), Congress gave the States much more flexibility to change basic parameters of the program, including which groups of people are served, which services are provided, how doctors, hospitals, and nursing homes are paid, and how care can be organized in innovative ways.

The Medicaid Program Evaluation addresses the implementation and impact of selected changes in the Medicaid program to provide knowledge for policy assessment and future legislative change. It is focused on selected issues and policy questions raised by recent legislation. The three-year evaluation includes nine major study areas:

- Federal Financial Participation
- Inpatient Hospital Reimbursement
- Eligibility
- Case Management
- Home and Community-Based Waiver Program
- Cost-Sharing
- Financial Incentives for Family Care
- Medicare PPS Effects on Medicaid and
- Synthesis.

Together these studies are intended to describe how recent changes have been implemented and analyze what their effects have been for program services and costs.

This document presents a case study of the Selective Contracting program initiated by the State of California for Medi-Cal inpatient hospital services in 1983. It addresses an area of great interest to policy makers because hospital inpatient reimbursement accounts for about one-quarter of all Medicaid program expenditures. The study reported here examines the ways in which government can alter the incentives for hospital utilization, costliness, and the quality of care. The experience of the innovative California program is presented as a resource for future policy debate.

PREFACE TO 1987 PRINTING

This report was originally prepared in December of 1984 as a Draft Report. It is being reprinted in November of 1987 as part of the collection of papers generated by the Hospital Inpatient Reimbursement Study Area of the Medicaid Program Evaluation. The text of this report is unchanged from its 1984 version.

For information on later developments in California and an empirical analysis of the effects of the Selective Contracting program on cost, utilization, quality of care, etc. the reader should consult S. Mennemeyer et al., Medicaid Program Evaluation, Cluster II, Inpatient Hospital Reimbursement, Final Report MPE Paper #3.8, November 1987.

ACKNOWLEDGEMENTS

It is not possible to list individually all the people who cooperated in the production of this report, most particularly the state, hospital and insurance company personnel who took time out from their busy schedules to meet with us and offer their frank and knowledgeable opinions concerning hospital contracting in California. Without their thoughtful help, however, we would not have had any report and we are deeply grateful.

We do not believe we will violate our pledge of anonymity for respondents by offering special thanks to officials of the State of California who were particularly hospitable and cooperative over the last year, especially through the long process of cleaning data. These include, Steve Thompson of the Assembly Speaker's Office; Tom Elkin of the Department of Health Services, Division of Operations; Neil Throckmorton, Dan Little and Marc Lowry, Department of Health Services, Fiscal Forecasting Section; Dan McCarroll, Center for Health Statistics; and Michael Murray, Jim Foley, and Keith Berger, California Medical Assistance Commission.

We also gratefully acknowledge the help of Gerald S. Adler, our HFCA project officer, who has provided support in numerous technical and logistical areas.

Finally, thanks to Roberta Brannigan for help with computer programming and Georgette Wright, our indefatigable contract secretary.

EXECUTIVE SUMMARY:
Selective Contracting in California: The First Year
Medicaid Hospital Reimbursement Project

The Omnibus Reconciliation Act of 1981 (OBRA)[1] revised the legal basis for reimbursing hospitals under Medicaid for the first time since the inception of the program in 1967. States were no longer required to reimburse on a cost basis and were allowed to obtain waivers from freedom of choice provisions. One of the most striking examples of state responses to this new flexibility was the initiation of the selective contracting program by the California Medi-Cal program. Selective contracting allowed the Medi-Cal program to contract with hospitals individually for participation in the Medi-Cal program. The terms and rates of providing services were part of the negotiation. This report is the first of a series of reports on the California experiment and on other changes in Medicaid hospital reimbursement approaches across the country.

This report is primarily a qualitative assessment of the first year of the California contracting experiment, although it also includes some important new quantitative analysis of the state's savings from contracting. It is based on over 100 interviews in California with state officials, hospital administrators, legislators, interest groups and consumers; and on analysis of the negotiated contracting rates. A subsequent California report will examine the second year of contracting and include analysis of access and quality of care issues. Additionally, this project will undertake a national overview of Medicaid hospital reimbursement practices--both current and over the last several years; an in-depth case study of Medicaid hospital reimbursement under DRGs in New Jersey; and less extensive case studies of Medicaid hospital reimbursement innovations in three to five additional states.

Genesis of California Contracting. Contracting in California was a response to a severe budget crisis, a hospital industry which strongly opposed previous attempts at rate-regulation, and consumer groups which wanted to see some cost containment efforts but had mixed feelings about rate-regulation. These factors coalesced in the late spring of 1982 to bring to the floor of the California Legislature a bill sponsored by legislative leadership creating a special negotiator outside of the Department of Health Services (DHS), the single-state agency. The special negotiator was empowered for one year to create a crash program to negotiate Medi-Cal contracts for inpatient services with individual hospitals and generate a $200 million savings. At the end of one year, the Governor's Office of Special Hospital Negotiations (GOSHN) would be replaced by the California Medical Assistance Commission (CMAC), a commission which would continue the program of contracting with hospitals and, additionally, become involved in potential capitation financing programs. Both GOSHN and CMAC were supported by DHS and had been given unusual latitude for government agencies through special exemptions from normal regulatory and disclosure requirements.

[1]For easy reference, Attachment F provides a glossary of all abbreviations used in this report.

William Guy, the retiring head of Southern California Blue Cross, was chosen as the special negotiator--or czar, as he was dubbed by the press. Within several months, he assembled a team of negotiators, received the necessary federal waivers, and began negotiating contracts with hospitals. The relegation of DHS to a secondary role by the enabling legislation led to some bureaucratic friction between GOSHN and DHS, but most problems were eventually overcome. Nevertheless, the actual start-up date of contracting was delayed for one month, until February, 1983, by a problem in the level of detail in contract language necessary for DHS to administer the contracts.

First Year Implementation. By all accounts, the crucial event in the implementation was the awarding of contracts in San Francisco, the first region to be negotiated. Guy concluded negotiations in San Francisco by announcing that three of the largest hospitals in the city would not receive contracts. Historically, these three hospitals had together served 40% of the Medi-Cal recipients in San Francisco. Exclusion of these hospitals sent a message to hospitals in the rest of the state that Guy was serious. In the days following announcement of the San Francisco outcome, the special negotiator's office was flooded with calls from hospitals in other areas reducing their bids. By the summer of 1983, 245 hospitals were under contract. Although contracting was not in effect in all regions of the state, the areas in which contracting was implemented were areas with high Medi-Cal concentration. These areas represented approximately 87 percent of Medi-Cal inpatient expenditures prior to contracting.

When an area was under contracting, Medi-Cal recipients could receive non-emergency care only at those hospitals who were under contract with the state. Emergency care was still available at non-contracting hospitals, but as soon as the patient stabilized he or she was to be transferred to a contracting hospital. While, in theory, this approach might have caused a great deal of patient relocation, in practice, relocation was minimal because contracts were awarded to most large Medi-Cal providers. In all, contracting hospitals had historically provided 85 percent of the services in those areas under contracting. (Even in San Francisco, Guy subsequently allowed the region to be rebid, thereby allowing the originally excluded hospitals to be returned to the Medi-Cal program.) Thus, contracting made no attempt to channel patients to lower cost hospitals, but rather focused on obtaining lower rates from hospitals already serving Medi-Cal recipients. Hospitals did not perceive themselves to be competing against one another for volume, but competing against savings targets established by the special negotiator. Hospitals typically characterized their bids as defensive bids--an attempt to keep current Medi-Cal occupancy, rather than an attempt to increase Medi-Cal business. In fact, hospitals spent considerably more energy trying to negotiate clauses in contracts to protect themselves from large increases in Medi-Cal volume than they spent in trying to generate such increases. Medi-Cal contracting at this stage can be more accurately characterized as negotiated rate-setting rather than a true competitive approach.

To a certain extent, this strategy was forced by the historic uneven distribution of Medi-Cal recipients. Certain types of hospitals had disproportionately large shares of Medi-Cal patients, particularly county hospitals, University of California hospitals, and certain urban hospitals affiliated with religious groups. For some of these hospitals, failure to

receive a Medi-Cal contract was tantamount to closure. Even if Guy had been willing to take the political risks of not awarding these hospitals a contract, it is unclear whether he would have been able to contract for sufficient access for Medi-Cal patients. The problem would have been particularly acute for the more specialized services, such as neo-natal nurseries. As a result, GOSHN was under more pressure to award contracts to some hospitals than to other hospitals. The hospitals GOSHN needed had more leverage in negotiations. These hospitals were able to negotiate contractual terms which hospitals less crucial to GOSHN had been told were impossible to negotiate. Perhaps more importantly, some of these critical hospitals were able to negotiate contracts with smaller rate decreases than the less critical hospitals.

In any event, the rate reductions resulting from contracting are impressive. There are several different ways to measure these reductions, all of which are discussed in the report. The most useful comparison is between rates paid under contracting and the rates which would have been paid had the previous system remained in place. We estimate that rates paid for services offered between the onset of contracting and September of 1983 are $546 per day, or 20 percent lower than they would have been under the old system. This reduction is based on interim rates, prior to the state's audit settlement at the end of each year. When an estimate of these final settlements is taken into account, the rate reduction is 13 percent. The difference between rates under contracting and rates which would have been paid under the old system will continue to grow because the previous system allowed hospitals to automatically increase their rates with inflation. Contracting does not adjust for inflation. Thus, savings against what would have been paid continue to grow by the rate of inflation which hospitals are experiencing.

The degree of rate reduction was not equal across all hospitals or types of hospitals. Several important generalizations stand-out. By far, the greatest savings were extracted from state teaching hospitals. County hospitals, on the other hand, experienced rate reductions slightly lower than average. Hospitals which were able to negotiate multiple rates--as opposed to the single all-inclusive rate preferred by GOSHN--had the smallest rate decreases.

The net effect of these lower rates is a drastic reduction in state expenditures, even with some offsetting increases in the per diems of non-contracting hospitals (which continued to handle emergency cases). The state estimates final aggregate savings at $140 million below what would have been spent for services provided in fiscal year 1983-84 and a cash flow reduction during that year of $179 million. We have carefully critiqued the state's methodology and made some calculations of our own, in addition to the analysis of changes in per diems. We take minor issue with several elements of the state's methodology for estimating aggregate savings, but the differences are small and we are confident that the state's estimates are of the correct order of magnitude.

Other Impacts of Contracting. For the most part, hospitals were not overly dissatisfied with the contracting process. Most hospitals which wanted a contract were able to obtain one. They felt contracting, while "loaded" in the state's favor, was preferable to a rate review approach and that the first year negotiations had been handled fairly by GOSHN staff. Hospitals were more

concerned about problems generated by the state's strenuous utilization control program which reviews utilization on a day-by-day basis in major urban areas. The recent legislation required full documentation for all inpatient services. Hospitals felt that the amount of "red tape" and the number of "arbitrary" disallowances were serious impositions. Data collected from two Medi-Cal field offices suggested that between five and eight percent of all patient days were initially disallowed, although some of those days were eventually allowed after appeal or the provision of additional justification of the treatment.

The impact on non-contracting hospitals varies by the hospital size and location. Most, though not all, non-contracting hospitals did not actually want a Medi-Cal contract. As a group, their relative participation in the Medi-Cal program had been declining even before the advent of contracting.

Hospitals generally felt the most important impact of contracting was not simply that it drastically reduced Medi-Cal rates, but that it changed the hospital finance environment by making it clear that buyers could take direct steps to control costs. Most hospitals we visited had undertaken serious measures to economize, but it was impossible to isolate the reasons for those changes since Medi-Cal contracting was only one of many changes in hospital finance taking place in the same period. Comparing American Hospital Association Panel Survey Data with quarterly data from the California Health Facilities Commission, however, suggests that the rate of cost growth in California may be relatively lower than the rate in the remainder of the nation. It is possible that the events in California have had a favorable impact beyond the impact of national trends.

The relatively small sample of private payers to whom we spoke, did not seem particularly concerned about potential cost-shifting resulting from Medi-Cal contracting, although they all assumed there had been some additional cost-shifting. They were, on the other hand, enthusiastic about the overall shift in hospital attitudes--which they perceived in much the same terms as hospital respondents--and about the possibility of instituting their own programs of selective contracting. Private insurance contracting had been specifically allowed by a companion-piece legislation to the bill establishing Medi-Cal contracting. While none of our sample insurance companies had yet enrolled significant numbers of consumers, all had negotiated contracts with providers and felt that in the next few years contracting by private insurers would lead to substantial savings over the conventional charge-paying approach.

Finally, there was no evidence of systematic harm to Medi-Cal recipients from contracting. There were some problems during the implementation period, especially in San Francisco which was one of the first areas phased-in and in which major providers had initially been excluded. But in other areas, and in San Francisco after the re-bidding, consumer advocates were able to identify problems in only a few isolated incidents. The state has also developed a rather extensive system for handling complaints from recipients, but almost all of the processed complaints were evaluated to be consistent with the provisions of the contract, and therefore acceptable. Most of the complaints resulted from uncertainty as to what services hospitals were obligated to provide. However, DHS reports showed a large number of unprocessed complaints.

Second Round of Contracting. As required by law, CMAC replaced the special negotiator in July of 1983. CMAC adopted a policy of no net increase in the second round of negotiations and has maintained that policy as of September of 1984. Thus, most Medi-Cal hospitals, after accepting substantial rate cuts in 1983, will go without a rate increase for at least twenty-four months. As of this writing, only three hospitals terminated their contracts with the state as a result of not getting a rate increase. Respondents generally attributed hospital acquiescence to California's severe overbedding and declining censuses which made hospitals desperate to protect their existing patient sources. In fact, during fiscal year 1983-84, CMAC actually contracted with 15 additional hospitals. CMAC believes it is advantageous to contract with as many additional hospitals as possible, as long as the new hospitals are offering rates lower than the existing hospitals in the area. This means, however, no hospital can gain a substantial volume advantage from contracting until rates become so low that more hospitals drop out of the Medi-Cal program.

It should also be pointed out that as of this writing not all the second round negotiations have been settled. The critical Los Angeles County hospital system and the University of California hospitals remain unsettled. Based on preliminary indications, it seems unlikely that CMAC will be able to maintain their no net increase policy for these hospitals. If CMAC gives these hospitals increases, it will illustrate the relative bargaining strength of these hospitals. It also suggests that there may some limits to market approaches in a political system.

Conclusions. Our general impression is that Medi-Cal contracting is a major success. Contracting generated a substantial reduction in Medi-Cal payments to hospitals and has slowed the growth of Medi-Cal payments to contracting hospitals to almost zero. It has accomplished this with a minimal amount of litigation, limitation on recipient access, or dissatisfaction from other payers. We also believe the approach has applicability to other states, but we do caution that there are certain features which are--at least by degree--unique to California, and may act to limit adoption of contracting by other states. These include:

* The severity of the fiscal crisis which motivated the General Asssembly to undertake action considerably more drastic than legislatures are generally inclined to take;

* The tremendous degree of excess bed capacity in California;

* The extraordinary skill of William Guy in using the first contracting area to demonstrate his seriousness; and

* The existence of some utilization review system controlling length of stay (if the reimbursement payment is based on per diems) or volume (if the reimbursement payment is based on per discharges).

We also believe that the forces which contracting has unleashed, however, are not unmitigatedly positive. For example, some hospitals with high Medi-Cal volume will potentially be unable to compete for private payers. While this is not a major trend at this point, states contemplating a contracting

approach should explicitly consider the possibility of creating a system of hospitals with a clientele composed exclusively of the poor.

For at least the time-being, however, Medi-Cal contracting seems quite successful.

CHAPTER 1

OVERVIEW

This report examines contracting for Medicaid hospital services in California. The Selective Provider Contracting Program is a system which allowed the state to contract for hospital services with individual hospitals, including the negotiation of rates and other terms. Hospitals which do not come to terms with the state are dropped from the program. Recipients are redirected to those hospitals which did meet the state's terms. During the first year, contracts were signed with 245 of the approximately 400 hospitals in areas where the state tried to implement contracting. These areas accounted for 87 percent of the historic Medicaid utilization. William Guy, the man chosen to head this program, claimed this change was the most significant change in hospital financing since the advent of Social Security.

This is the first in a series of reports describing and evaluating changes currently taking place in Medicaid inpatient hospital reimbursement. These reports have two broad purposes: to provide a general overview of the changes taking place and to offer detailed information on possible models for Medicaid hospital reimbursement. This chapter will provide a general introduction both to the entire Medicaid Hospital Reimbursement Project and to the specific report on California hospital contracting.

1.1 Medicaid Hospital Reimbursement Project

Historically, Medicaid hospital payment has rested on two broad concepts: cost-based reimbursement and freedom of choice. These concepts furthered the goal of the Medicaid program to increase access to mainstream

medicine for the poor. Cost-based reimbursement assumed that the most equitable manner of hospital reimbursement for Medicaid recipients was to reimburse a share of the hospital's actual costs proportionate to the Medicaid share of utilization. Medicaid recipients would also be free, according to the second principle, to receive care in whichever hospital they wished. Thus, Medicaid recipients would enjoy the same access available to any other insured segment of the population.

The Medicaid program, formed by these two concepts, generally worked well to increase access to hospitals for the poor. Unfortunately, as is now universally recognized, these two concepts had other effects. As hospital costs soared--partially in response to cost-based reimbursement--Medicaid programs had neither a basis for lowering unit costs nor for directing patients to less expensive hospitals.

Throughout the seventies, dissatisfaction with this approach to hospital reimbursement for both Medicare and Medicaid grew. Demonstration waivers were granted allowing selected states to control the rate of Medicaid growth by directly regulating the rate of increase in hospital expenses. These programs, through a series of regulatory mechanisms, more or less dictated the amount by which hospital rates could increase from one period to the next. But these programs continued to require special waivers which were difficult to obtain and the freedom of choice provisions were untouched.

In 1981, Congress adopted the Omnibus Budget Reconciliation Act (OBRA) which included the most radical changes in Medicaid reimbursement since the onset of the program. States were given the latitude to design alternative reimbursement systems and to obtain waivers from the freedom of choice provisions. With this legislation, both historical lynchpins of Medicaid hospital reimbursement were pulled.

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The Medicaid Hospital Reimbursement Project is one of several evaluations currently under way by the Health Care Financing Administration to assess the impact of OBRA.[1] The project has two main components, a National Impact Study of changes in Medicaid hospital reimbursement and a series of case studies of individual states.

The National Impact Study will consider national Medicaid hospital experience as described in the HCFA 2082 data series.[2] It will offer a brief description and analysis of readily identifiable trends. The purpose will be to determine whether states with some form of alternative reimbursement for their Medicaid program generally have expenditure increases less than those with traditional systems. The first national impact report will be submitted to HCFA late in 1984 and will cover changes made through 1982. The report will be updated in 1985 and 1986 to include changes made through at least 1984.

In addition to the national overview, there will be two major case studies, one on New Jersey and one on California's selective contracting program. Additionally, there will be three to five smaller state case studies of emerging program changes.

The California hospital contracting program was chosen for study because it is one of the most innovative approaches to hospital reimbursement yet tried; no other program uses as much of the new latitude given to states by OBRA. The New Jersey DRG program was chosen because it is the only

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[1]Other evaluations focus on alternatives to long-term care, results of eligibility changes, and examples of primary-care management systems, among other aspects of the OBRA changes.

[2]HCFA 2082 forms are annual reports by states to HFA detailing their expenses for the reporting year.

Medicaid program which has reimbursed on a DRG-basis long enough to develop sufficient outcome data.[3] With the extended use of DRGs by Medicare, more states will consider DRG approaches. (Utah, Ohio and Pennsylvania are already using DRGs for Medicaid Reimbursement and several other states, including Michigan and Minnesota, are considering their adoption.) The first New Jersey case study report will be submitted to HCFA sometime in early 1985.

Sites for the smaller case studies have not yet been identified. These studies will focus on states which have made changes in their Medicaid program which either provide interesting examples for other states or illustrate typical problems encountered by changes in Medicaid reimbursement. First reports on these studies will be available in 1985.

This report examines hospital contracting in California. The remainder of this introductory section provides an overview of the study and the methodology employed by Abt Associates (AAI), and its subcontractors, Compass Consulting Group and Health Economics Research, in conducting the California case study. Following this overview is a description of the organization of the report.

1.2 Methodology

This report is primarily qualitative in nature. While Chapter 6 includes some original and important data analysis, the primary sources for this report are a series of interviews with various major actors in California and an extensive review of the available literature. A second report, which will integrate extensive quantitative analysis with the qualitative data from this report, will be completed in the second year of the project.

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[3] DRGs (Diagnosis Related Groups) are a system for assigning reimbursement to individual cases based on the diagnosis.

This preliminary report reflects a trade-off between the high degree of immediate interest in the California contracting program and the long delays in the availability of data. Because of the staggered nature of contract implementation and the usual delays in hospital and state claims processing, data for a full year under contracting will not be available until late in 1984. Both the Health Care Financing Administration and Abt Associates feel the degree of interest in the California program necessitates this preliminary report.

Exhibit 1.1 summarizes the interviews on which this report is primarily based. Respondents included state and legislative staff, representatives of major interest groups, hospital opinion leaders, private payers, consumer advocates, and other researchers. In addition, a sample of 18 hospitals--both contracting and non-contracting--were visited by the site team. Generally, the Chief Executive Officer, the Chief Financial Officer, the Director of Nursing, and the Medical Director were interviewed. In several hospitals, the Director of Utilization Review and other hospital staff members involved with contracting were interviewed in addition to or instead of the above.

The hospital sampling strategy was based on health care delivery systems, rather than sampling individual hospitals across the state. Four health care delivery systems were chosen, based on California's designation of Health Facility Planning Areas (HFPAs). A sample of hospitals in selected

Exhibit 1.1

SUMMARY OF INTERVIEWS CONDUCTED BY TYPE RESPONDENT JANUARY TO MARCH 1984

Hospital Site Visits	18
Hospital Opinion Leaders	9
Medical Lobbies	5
Legislators or Staff	5
CMAC Commissioners[a]	3
CMAC or GOSHN Staff[b]	6
Insurance Companies	4
California Department of Health Services (DHS) Field Offices	5
Other DHS Staff	11
Consumer Advocates	6
Other Researchers	4
County Officials	2
Other[c]	5
TOTAL	83

[a]California Medical Assistance Commission (CMAC) is the board which is currently responsible for negotiating contracts with hospitals

[b]Governor's Office of Special Hospital Negotiations (GOSHN) was the predecessor of CMAC.

[c]Includes other state agencies, HCFA regional office, and Medi-Cal fiscal intermediary.

HFPAs were visited[4]. The four types of health care delivery systems included were:

* An inner-city area with high Medicaid concentration;
* A non-inner city area with high Medicaid concentration;
* A suburban area with relatively low Medicaid concentration; and
* A medium-sized city.

In addition to hospitals, staff from the California Department of Health Services (DHS) Field Offices and a local consumer advocate were interviewed in each of the HFPAs.[5]

In total, 22 hospitals were targeted for site visits. Three declined to participate and one agreed to participate but scheduling difficulties precluded its participation. Exhibit 1.2 summarizes the hospital sample in terms of contracting status, ownership type, bed size and California Health Facilities Commission peer group assignment and compares the sample to all hospitals in the state in areas where contracting was in effect. It can be seen that the sample of hospitals visited was similar to the state in terms of contracting status and ownership type, but was biased toward larger hospitals. This result is not a serious concern since most Medi-Cal services are, in fact, provided in larger hospitals.

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[4]The initial plan was to visit all acute care hospitals in the selected HFPA. But this was only done in one HFPA. In the inner-city HFPA, the number of hospitals was too large to interview all hospitals. After discussion with state officials, staff of the California Hospital Association, and the local Medical Foundation, a particular market area within the HFPA was identified as the sample. In another HFPA, a hospital was not included because of its historically negligible participation in Medi-Cal. Finally, in another HFPA it was necessary to include two hospitals from an adjacent HFPA in order to fairly approximate the market area.

[5]The Department of Health Services maintains 12 Medi-Cal field offices across the state whose primary responsibility is to handle questions and problems from consumers and providers in the day-to-day management of the contracts. The Field Offices also conduct the prior authorization and utilization review function on a daily basis.

Exhibit 1.2

CHARACTERISTICS OF SAMPLE HOSPITALS
COMPARED TO STATE HOSPITAL CHARACTERISTICS

	Number in Sample	Percent in Sample	Number in State[a]	Percent in State
Contract Status				
Contracting	13	72%	245	67%
Noncontracting	5	28%	120	33%
Ownership				
Nonprofit	10	55%	187	51%
Investor	5	28%	123	34%
City, county or district	3	17%	55	15%
Bed Size				
1-99	1	6%	127	34%
100-299	9	50%	161	44%
300+	8	44%	77	22%
Peer Group[b]				
Teaching	3	17%	21	6%
Large complex	8	44%	68	19%
Moderate size	5	28%	92	25%
Small urban	2	11%	107	29%
Other	-	-	77	21%
TOTAL HOSPITALS	18		365	

[a]Source: Calculated from data for non-exempt hospitals in HFPAs subject to contracting as of August 1, 1983 as presented in California Department of Health Services, First Annual Report to the Health Care Financing Administration on the Selective Provider Contracting Program, August, 1983.

[b]All California hospitals are assigned to peer groups by the California Health Facilities Commission.

The site visits were conducted from January 15 to March 15, 1984 by Abt Associates, in conjunction with Compass Consulting Group and Health Economics Research. Interview protocols were developed and used to structure the interviews (see Attachment A). Follow-up telephone calls in the subsequent months supplemented the on-site interviews.

1.3 Hospital Industry in California

There are certain features of the California hospital industry which shape the particular context in which contracting was operating. This section provides some general background on California hospitals.

Exhibit 1.3 presents basic data on California hospitals--the number of hospitals, bed size and type of ownership. As can be seen, the state has a large number of hospitals--around 500 community hospitals--and their size distribution closely mirrors that of the rest of the country. Ownership status, however, is markedly different. Investor ownership is much more important in California than in the rest of the nation. Nonprofit and government ownership is correspondingly lower. (The lower percentage of government ownership is despite California's historically strong commitment to county hospitals.)

Exhibit 1.4 shows two areas where California hospitals differ significantly from those in the rest of the nation--occupancy and length of stay. Both are considerably lower than the national averages. Exhibit 1.4 also compares the market share of HMOs in California with the rest of the nation. HMOs in California have a market share about five times greater than that of the rest of the county.

Exhibit 1.4 also compares the distribution of hospital revenue by Medicaid, Medicare and other payors. As can be seen, Medicaid has a substan-

Exhibit 1.3

GENERAL CHARACTERISTICS OF ALL CALIFORNIA HOSPITALS, 1981[a]

TOTAL NUMBER	California Health Facilities Commission[b]	= 546
	(less psychiatric and long-term hospitals)[c]	= 494
	AHA (short-term community hospitals)[d]	= 501

BED SIZE

	CHFC[b]	AHA/National[e] (All)	AHA/California[d] (Med-surg)	AHA/National[e] (Med-surg)
1-99	46%	45%	42%	46%
100-299	38%	35%	42%	36%
300+	16%	20%	15%	18%

OWNERSHIP

	CHFC[b]	AHA/California[d] (Med-surg)	AHA/National[e] (Med-surg)
Nonprofit	46%	49%	57%
Investor	38%	29%	13%
Government	16%	22%	30%

[a]Because different data sources use different definitions in various categories, both California Health Facilities Commission (CHFC) and American Hospital Association (AHA) Statistics are presented. Note that the total number of hospitals is different from that shown in Exhibit 1.2 because that exhibit included only hospitals in areas where contracting was implemented. CHFC data is for hospital fiscal years ending on June 30, 1981 to June 29, 1982. AHA data is from hospital questionnaires covering the year from October 1, 1980 to September 30, 1981. Some percentages do not total to 100% because of rounding errors.

[b]CHFC, Individual Hospital Data (Report 11-83-10). All hospitals except state, Kaiser, Shriner and dental hospitals. Includes psychiatric and other specialty hospitals.

[c]AAI calculation from CHFC Report

[d]Includes only short-term general and other special non-psychiatric hospitals, AHA, Hospital Statistics, 1982 Edition, p. 48.

[e]AHA, Hospital Statistics, 1982 Edition, p. 20.

Exhibit 1.4

CALIFORNIA VERSUS NATIONAL OUTPUT AND MARKET CHARACTERISTICS

Occupancy, 1981

CHFC[a]	AHA/California[b] (Med-surg)	AHA/National[c] (Med-surg)
63%	70%	76%

Length of stay, 1981

CHFC[a]	AHA/California[b] (Med-surg)	AHA/National[c] (Med-surg)
7.0	6.6	7.6

HMO Penetration, 1983

California[d] = 21%
Rest of Nation[e] = 4%

Distribution of Volume by Payer Type, 1981

	California[f]	National[g]
Medicare	37	37
Medicaid	18	10
Other	45	53

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[a]CHFC, Individual Hospital Data, (Report 11-83-10). Includes all hospitals except state, Shriner, Kaiser and dental hospitals.

[b]AHA, Hospital Statistics, 1982 Edition, p. 48. Includes only non-psychiatric short-term general and specialty hospitals.

[c]AHA, Hospital Statistics, 1982 Edition, p. 20.

[d]InterStudy, 1983.

[e]AAI Calculation from data supplied by InterStudy. (Note: This is not the national average but the average for the rest of the country.)

[f]CHFC, total gross charges for hospital services, inpatient and outpatient. All hospitals, except Kaiser, state, Shriner and dental hospitals.

[g]Derived from unpublished tabulations from AHA annual survey as reported in Ginsburg and Sloan, "Hospital Cost Shifting," New England Journal of Medicine, Vol. 310, No. 14 (April 5, 1984), p. 895.

tially higher share in California than elsewhere, in part, no doubt, due to the difference in HMO penetration. The Medi-Cal market share strengthens their leverage, although, these figures inflate current Medi-Cal leverage because certain types of Medi-Cal patients were not covered by contracting. (See Chapter Two.)

Exhibit 1.5 shows some financial information on California, including total revenue, total expenses, and expenses per discharge and per day compared to the national average. These figures show that, despite the lower lengths of stay in California hospitals, the average per discharge cost is about one-third more expensive than the national average.

In sum, the hospital industry in California is very different from that in the rest of the country. It has more investor owned hospitals, more HMOs, lower occupancy, shorter lengths of stay, greater concentrations of Medicaid patients, and is considerably more expensive. The impact of these characteristics will be seen in the following chapters which address the contracting program itself.

1.4 Organization of the Report

The remainder of this report is divided into ten chapters. Chapter 2 summarizes the events surrounding the adoption and implementation of selective contracting for Medi-Cal, as the California Medicaid program is called. Chapter 3 sets forth the major administrative issues faced by the state in attempting to implement such a radical change.

The following two chapters consider the process of actually negotiating contracts with hospitals. Chapter 4 considers the process from the state's point of view, including descriptions of the major strategic and tactical issues faced by the state and their resolution in the actual process

Table 1.5

FINANCIAL INFORMATION
CALIFORNIA AND NATIONAL, 1981

Total California Revenue[a]

Inpatient and Outpatient	$9,611 million
Inpatient	$8,335 million

Total California Expenses[a]

Inpatient and Outpatient	$9,749 million
Inpatient	$8,177 million

Unit Cost, California and National

	CHFC[a]	AHA/California[b] (Med-surg)	AHA/National[c] (Med-surg)
Per Discharge	$2813	$2809	$2171
Per Day	$ 404	$ 428	$ 284

[a]CHFC, Individual Hospital Data (Report 11-83-10). All hospitals except state, Kaiser, Shriner and Dental Hospitals. Figures also adjusted to remove physician costs to increase comparability.

[b]AHA Hospital Statistics, 1982 Edition, p. 48. Includes only non-psychiatric, short-term general and specialty hospitals.

[c]AHA Hospital Statistics, 1982 Edition, p. 20.

of negotiation. Chapter 5 considers the negotiation process from the hospital's point of view.

Chapter 6 considers the results of contracting from two perspectives. First, it analyzes the characteristics of hospitals receiving contracts and the relationship of the negotiated rate to other factors. Second, it examines the state's estimates of savings from contracting.

Chapters 7, 8, and 9 address the impact of contracting on patients, other payers and hopsitals, repectively. Chapter 10 describes how the hospital contracting process in California is being institutionalized. The last chapter, Chapter 11, explores the appropriateness of this program for replication in other states.

CHAPTER 2

ADOPTION AND IMPLEMENTATION OF HOSPITAL CONTRACTING

The purpose of this chapter is to provide an appropriate context for the discussion and analysis of the specific issues addressed in subsequent chapters. This chapter outlines Medi-Cal's historic involvement in hospital reimbursement issues, provides a brief history of the events leading up to the passage of legislation which authorized hospital contracting, and gives a chronology of the main events in implementing contracting.[1]

2.1 Medi-Cal and Hospitals

Medi-Cal in California is an enormous program. Since its inception in 1966, Medi-Cal had grown to the point where in 1980 it was providing Medicaid benefits to over three million recipients, including Medically Needy coverage and a state-funded program for Medically Indigent Adults (MIA's). Moreover, the state is relatively generous, providing an extensive list of services beyond those required by federal law. In 1981, total payments to providers exceeded $4.1 billion, second only to New York State.

Hospital costs, which increased by almost 19 percent nationwide, between 1981 and 1983 have also been a subject of contention in the Medi-Cal program.

The search for an alternative to cost-based reimbursement started as early as 1971. At that time the California Hospital Association (CHA) favored

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[1]Readers desiring greater detail on the circumstances leading up to the passage of Medi-Cal contracting are referred to the report on "Selective Contracting for Health Services in California" prepared by Lucy Johns, Robert Derzon and Maren Anderson, Lewin and Associates, Inc., September 1983, for the National Governor's Association. Readers familiar with the Johns et al. report might want to proceed directly to Chapter Three.

hospital rate regulation as an approach to payer equity, with the understanding that there would also be some moderation in the rate of cost growth. Commercial insurers also supported hospital rate regulation as a way of controlling costs and, in 1971, legislation was passed establishing mandatory reporting and disclosure of hospital costs as a preliminary step toward rate regulation. The California Health Facilities Commission (CHFC) was created to collect data and, it was assumed, evolve into the rate setting body.

However, support for a rate-setting approach diminished rapidly and as the 70's went on, no further progress was made in turning the CHFC into a true rate regulation body.[2] Once the impact of the Economic Stabilization Program wore off in the mid-70's, hospital inflation again became a major issue. In 1978, legislators gave the health industry its "last chance" to control hospital costs before government intervention. The CHA and the California Medical Association (CMA), two very powerful lobbying groups, convinced the legislature to allow them to undertake a "voluntary effort" at cost-containment. An annual ceiling on hospital rate increases was identified and hospitals agreed to keep their rate of increase below that level. This was a short-lived effort and costs took off again.

Anticipating the failure of this voluntary effort, in June 1981 the legislature enacted AB 251, also known as "Medi-Cal's Six Percent Solution." Medi-Cal inpatient reimbursement, in fiscal years 1981-1982, was limited, on a per discharge basis, to six percent above the previous year's reimbursement. In addition, DHS was required to experiment with alternative methods of Medi-Cal management on a limited basis. However, the necessary federal waivers were not granted quickly and the six percent cap was challenged in court by

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[2]Albert Lipson "The California Health Facilities Commission: A Case Study of Government Regulation," Rand Research Report prepared under contract to HCFA (R-2220-HCFA), November, 1977.

CHA. Six months after AB 251 was passed, the court declared AB 251 invalid. DHS was forced to restore interim hospital payments rates to levels in effect prior to January 15, 1982 and was unable to implement its pilot projects.

The state estimated that Medi-Cal payments would reach $4.3 billion during the 1982 Fiscal Year, consuming over 15 percent of the state's General Fund budget. Medi-Cal had been growing at annual rate of 14 percent since the mid-1970s.[3]

Since 1978, however, the state had faced a limited capacity to raise revenues. Property taxes, a major source of local revenues, had been reduced by 50 percent when Proposition 13 became effective in June 1978. Additional local revenue restrictions were enacted in November 1979. These initiatives put great pressure on the state to increase support for local government functions. Proposition 4 limited local and state appropriations increases and prevented local and state governments from retaining surplus funds.

In addition to the inability to raise local revenues, the general fiscal condition of California deteriorated because of the national economic recessions in 1980 and 1981. In January 1982, projected state revenue growth was the lowest for any fiscal year in recent California history. Unemployment, industrial growth, taxable sales and other economic indicators were all below projections.

Compounding California's potential revenue shortfall was the federal government's fiscal crisis. The Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) reduced the federal share of Medicaid reimbursement by three percent in 1982, four percent in 1983, and 4.5 percent in 1984. The estimated impact of these reductions was to decrease California's General Fund revenues

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[3]L. Johns et al. Selective Contracting, September 1983, Appendix B, p. 4.

by $76.9 million in 1982-83. The net effect of these factors was a projected 1982-1983 budget deficit of $2 billion, a projection that made the legislature's constitutional obligation to balance the state's budget, a formidable task. Given the climate of the previous "tax revolts," raising taxes to increase revenues was not a viable alternative. Reducing expenditures was the only option.

Medi-Cal, as one observer notes, was a "ripe target" for cutbacks in 1982.[4] The previous legislative session had reduced the state's AFDC program, leaving Medi-Cal and education as the remaining major budget items susceptible to further savings. However, Proposition 13 had already left its imprint on the educational sector by reducing local revenues. Thus, there was little choice but to target Medi-Cal for "draconian budget cuts".[5] In the spring of 1982, the legislature agreed to slash $500 million from the Medi-Cal budget without knowing where or how that $500 million would be cut.

2.2 Passage of AB 799, AB 3480, and SB 2012

In March 1982 a small bipartisan working group of legislative leadership began to meet weekly to develop proposals for Medi-Cal reform. No consensus on achieving the $500 million budget cut prevailed. The proposals included the traditional options of eliminating or reducing benefits, restricting eligibility, and decreasing reimbursement rates. Hospital rate regulation, favored by many legislators and by consumer, labor, and elderly

[4]Ibid., p. 29.

[5]CHA Insight, Vol. 7, No. 16, March 28, 1983.

groups, was seriously debated with intense opposition from health care industry lobbyists.

Selective hospital contracting, in a number of configurations, was also discussed. Contracting was not a new concept to the legislature. In 1972, one form had been implemented within the Medi-Cal program as pre-paid health care, although with rather mixed results. Contracting was further studied by the DHS in 1978, and each year thereafter, contracting was unsuccessfully recommended or introduced into the legislature. However, in 1982, the factors that previously precluded selective contracting from serious consideration were conspicuously absent. The CHA and CMA had been defeated by their own "voluntary effort", traditional party rivalries were set aside to develop proposals for reforms within the working group, and the state could not balance the budget without substantial cuts. Furthermore, possible barriers to implementation were removed when the Federal Omnibus Budget Reconciliation Act of 1981 gave states more flexibility in adopting alternatives to cost-based reimbursement and allowed waivers of beneficiary freedom of choice provisions.

The coalition of consumers, the elderly, labor and employee benefit managers continued to call for all-payer regulation. However, the California Business Roundtable stated strongly that it did not favor government controls. The roundtable's position, and endorsement of contracting by a small number of independent Los Angeles hospitals, seemed to push the legislators toward contracting as a possible solution. However, a DHS working paper reported that selective contracting would take three years to implement--too late to affect the current deficit. Legislative leaders responded to the DHS conclusion with an approach that circumvented bureaucracy: a "special negotiator" outside DHS would negotiate selective contracts.

It was at this point that William Guy, retiring president of Southern Blue Cross was invited to speak with the then Governor Brown and legislative leadership. Their discussion focused on the feasibility of such a contracting program. Mr. Guy, familiar with hospital contracting through his experience with negotiating inpatient reimbursement rates for Blue Cross' HMO, insisted that contracting was possible, but with one crucial caveat: if contracting was to be effective, it had to be implemented quickly by one person with complete authority.

At least partially under Guy's influence, the Legislature promptly drafted legislation incorporating hospital contracting into AB 799, a bill proposing other Medi-Cal amendments. The perception that hospital contracting would introduce "competition" into the health care system attracted instant legislative support. Indeed, an approach that created incentives to reduce hospital costs without crossing the health industry's opposition to regulation was hard to resist.

The CHA and CMA reactions to AB 799, however, were far from supportive. While the CHA publicly endorsed the principle of "competition," it argued that the legislature's proposal lacked adequate safeguards to insure access and quality of care. Similarly, CMA perceived contracting to be a threat to the fee-for-service model and to their freedom of medical practice. Thus, the powerful lobbies of CHA and CMA, with their long-standing record of defeating major reforms in the health care system, vehemently criticized the legislation. However, they did not offer any alternatives to help solve the fiscal crisis, and, for the first time in years, the legislature did not succumb to the lobbies' pressures.

The insurance industry, on the other hand, saw AB 799 as an opportunity to strike a blow in their own war against hospital inflation. Tradi-

tionally, insurance companies paid "customary and reasonable" charges, as set by hospitals. However, if the insurance industry was granted the same hospital contracting privileges as the state, insurers could gain a measure of control over the rates. Furthermore, insurance industry analysts realized that Medi-Cal contracting could increase hospital charges to private patients. This potential increase in cost-shifting inspired a simple solution: replace the "freedom of choice" clause from the Insurance Code with a provision allowing insurers to negotiate with hospitals for "alternative rates." "Competition" would be introduced into the private health care sector as well. AB 3480 was quickly drafted and tied procedurally to AB 799, and both were tied to the budget. The details of both bills were worked out in conference committee and, given the tight time framework and the absence of the usual committee process, it is unclear whether all members of the legislature had time to fully understand the provisions of the two bills. Nevertheless, the bills were passed and signed into law on June 29, 1982.

By all accounts, the legislative process that passed AB 799 and AB 3480 was atypical. The speed with which the bills were passed, the dismal conditions of the state budget, the bipartisan support, and the unsuccessful lobby efforts by CHA and CMA contributed to a very unusual process. Yet, one of the greatest surprises was the influence of Mr. Guy. One Senate staff member remarked: "That is the first time I have ever seen a bill drafted to fit a person." This comment reflects the impression that Guy had on the legislature, and suggests the degree to which he was firmly linked to the contracting concept in the minds of legislators.

2.3 The Legislation

The legislation enabling Medi-Cal hospital contracting is embodied in two statutes: Assembly Bill 799 (AB 799) and a "clean-up" bill, Senate Bill 2012 (SB 2012). In addition to establishing selective contracting with Medi-Cal, these two bills authorize benefit and eligibility reductions. Both Democratic and Republican leadership emphasized that these reductions were made reluctantly as a result of the "painful economic realities" of balancing the budget. The total fiscal package of reductions and program reform was estimated to save $372 million in state funds, during the 1982-1983 fiscal year, rather than $500 million as originally planned.[6]

The most significant benefit change adopted by the Legislature narrowed the definition of "medical necessity." Previously, the standard for furnishing Medi-Cal benefits simply required a "medical necessity" with the interpretation left largely to be worked out between providers and field offices. However, AB 799 fundamentally changed the standard to include only services that are "medically necessary to protect life or prevent significant disability." The effect of this change was to deny coverage for many elective services which were formerly provided. Coverage for elective surgery and medical procedures, drug products, podiatric and therapy services, vision care and dental services were all significantly reduced. This new definition is administered by the state's prior authorization system.

In addition to the benefit reductions, Medi-Cal reimbursement rates to providers were reduced. Reimbursement was generally reduced by ten percent for the following services: physician and hospital outpatient services;

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[6] 1982 Medi-Cal Changes: Implementation of AB799 Including SB 2012 and Pending Court Actions, DHS, September 20, 1982, pg. 1.

hearing aids; acupuncture, portable X-ray, chiropractic and psychology services; and drug dispensing, laboratory, and pathology fees.

The most dramatic eligibility change eliminated the MIA eligibility category from the Medi-Cal program and required county governments to assume responsibility for this population. Counties were given the authority to determine what services will be provided and by whom. Approximately 270,000 MIAs statewide were affected by this shift in responsibility. However, counties were funded with only 70 percent of the costs that would have been expended under Medi-Cal for the period of January 1 through June 30, 1983. As predicted, this shift in MIA responsibility produced a greater savings in general fund expenditures than any other provision of AB 799 - including contracting.

In addition to eliminating the MIA category from Medi-Cal, other eligibility reductions embodied in the legislation required potential recipients to spend more of their own money on their health care needs each month before becoming eligible for Medi-Cal. Specifically, the needs standard for Medi-Cal was reduced to the lowest level that would qualify California for federal financial participation; special income deductions for the aged, blind, and disabled were eliminated; Medi-Cal coverage for the optional Aid to Families with Dependent Children-Unemployed Adults (AFDC-U) was eliminated; parental responsibility for children over 18 was increased; verification of Medi-Cal application information was required before eligibility determination; and real estate value limits were reduced.

2.4 Hospital Contracting

Hospital contracting, like the changes in benefits and eligibility, was contained in AB 799 and was intended to generate short-run savings. For FY 1982-83, hospital contracting was estimated to save approximately $100

million in general funds. However, hospital contracting also contained the potential for long-run savings and efficiency because of the fundamental change in the delivery and reimbursement of Medi-Cal services.

AB 799 authorized the Governor to appoint a "special negotiator to negotiate rates, terms and conditions for contracts with hospitals for inpatient services to be rendered to Medi-Cal program beneficiaries." The special negotiator had "maximum discretion and flexibility" to arrange the provision of health services, as long as significant savings are achieved. AB 799 also allowed the negotiator to seek bids if he felt that would be more expedient than conducting negotiations.

The negotiator was to serve for one year, from July 1, 1982 to June 30, 1983, at which time a seven member commission, the California Medical Assistance Commission (CMAC) was to assume all duties, and the special negotiator would become the executive director of CMAC. To expedite the negotiator's responsibilities, all rules and regulations were "deemed to be an emergency...(and) not subject to the review or approval of the Office of Administrative Law." To insure the special negotiator's authority, AB 799 was amended whereby activities "which reveal the special negotiator's deliberative processes, impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy" were exempted from public disclosure. The special negotiator was indeed afforded extreme liberty to achieve savings.[7]

In addition to considering the total appropriation, AB 799 specified nine standards (in Section 14083) which must be taken into consideration by contracting, including protecting beneficiary access, recognizing the severity

[7]SB 2012, Section 2, ¶6254.

of illnesses, insuring the availability of specialized services, and maintaining the quality of care.

Inpatient services provided by childrens' and charitable research hospitals were exempted from the negotiator's provisions, as were inpatient services to beneficiaries "who live or reside farther than the community ravel time standard from a contract hospital...if the hospital providing services is closer than a contract hospital."[8]

The seven member CMAC established by AB 799, was to assume all the negotiator's responsibilities as of July 1, 1983. CMAC, however, took office as of January 1, 1983, six months prior to relieving the negotiator of his duties. During this overlapping tenure with the negotiator, CMAC was required to "monitor and review" the activities of the negotiator.

As mentioned previously, AB 3480, a companion bill tied procedurally to AB 799, allowed similar contracting arrangements for the insurance industry. While not a focus of this study, commercial insurers' new ability to contract with providers is closely related to the process of Medi-Cal contracting. One of the more interesting questions is whether commercial insurers and Medi-Cal will eventually compete for the same beds, with the result that Medi-Cal will find it difficult to contract at desirable rates in some markets.

AB 3480 authorized insurers to offer two types of health insurance arrangements to its subscribers: preferred provider and exclusive provider packages. Effective July 1, 1983 an insurance company could:

> ...negotiate and enter in contracts for alternative rates of payment with institutional providers, and offer the benefit of such alternative rates to insureds who select such providers.[9]

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[8]Ibid., Section 40, ¶14087(c).
[9]AB 3480, Section 8.

Such contracts could also be negotiated with non-institutional, or professional, providers commencing July 1, 1983. While not stated explicitly in the legislation, the above arrangement is generally referred to as a Preferred Provider Organization (PPO). The insured can use any provider, but if he chooses to receive care from the preferred provider, he will benefit from the alternative rate.

On the other hand, insurance companies could restrict traditional consumer freedom. Effective July 1, 1983, insurers could negotiate and enter into contracts which:

> limit payments under a policy to services secured by insureds from institutional providers charging alternative rates.[10]

Although the term was not used in the law, these arrangements are often referred to as an "exclusive provider organization" (EPO). Subscribers using non-preferred providers will not be reimbursed. Reimbursement will be made only in the event that the subscriber uses the insurer's designated preferred provider. Finally, the clean-up bill, SB 2012, mandated the Department of Insurance to regulate the provision of EPO's to ensure that EPO contracts:

> ...include programs for the continuous review of the quality of care, performance of medical personnel, [and] utilization of services and facilities and costs by professionally unrelated third parties.[11]

2.5 Implementation of AB 799

Implementation of AB 799 was carried out with the same speed and fervor that characterized its passage. Selection of the special negotiator, or "Czar' as the press appropriately dubbed the position, was made in early July 1982, less than two weeks after the enactment of AB 799. To no one's surprise, William Guy was named special negotiator. Not only were Mr. Guy's

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[10]Ibid., Section 8.7.
[11]SB 2012, Section 10.

qualifications superb, but he was politically acceptable as well. Initially, Mr. Guy was reluctant to accept the position, as his immediate plans included retiring to Maryland. However, with reference to the stipulation that the position of Czar exist for only one year, Mr. Guy accepted the position. Several respondents characterized the decision as Mr. Guy's "swan song".

The special negotiator's first task was to assemble a staff capable of conducting negotiations with some 500 hospitals. There were no job descriptions, yet ten people were hired: two assistants, six negotiators, a data manager, and a student intern. All positions were exempt from civil service and resided in the executive branch of the Governor's Office of Selective Hospital Negotiations (GOSHN). Guy sought people with health care experience, but expertise in health care finance, law, or Medi-Cal administration was not necessary. Guy wanted people who would not be intimidated by a negotiation process. The process and criteria used to hire GOSHN staff reflects the non-bureaucratic style Guy was known for. As one respondent noted, "Guy worked out of his hip pocket; there is no paper trail."

Another early task was the development of waiver requests to the Federal government. This turned out to be significantly more time-consuming and arduous than originally imagined by Guy who was, in any event, inclined to see the waivers as bureaucratic details. Nevertheless, in August 1982, DHS and GOSHN jointly submitted requests for four waivers from California's state plan:

1) Freedom of Choice Waiver: This waiver allowed the state to restrict beneficiary choice to hospitals awarded a Medi-Cal contract;

2) Single State Agency Waiver: This waiver allowed the state to create GOSHN and CMAC as entities separate from the DHS, the single state agency responsible for administering the Medi-Cal program;

3) Alternative Payment Waiver: This waiver allowed the state to negotiate alternative rates of payment that do not necessarily meet the "reasonable and adequate rate" requirement;

4) Statewideness Waiver: This waiver allowed the state to phase in the implementation of hospital contracting; and

With the waiver requests into HCFA, GOSHN started to develop a strategy to implement hospital contracting. AB 799 left most of the contracting details to the discretion of the special negotiator. Guy and his staff had many policy decisions to make including the treatment of beneficiary access and quality of care, the method of reimbursement, the contract form, geographic specifications for negotiation, and the framework for the negotiation process. Similarly, DHS had to design a management monitoring system.

The provisions of AB 799 specified that the negotiator had the choice of "call(ing) for bids in lieu of negotiat(ing)" contracts with hospitals. But GOSHN favored negotiating contracts with individual hospitals over issuing a formal RFP. However, as will be described later, the process that emerged was more of a hybrid reflecting elements of each approach.

The first of nine criteria, expressed in Section 14083 of AB 799, required that GOSHN consider beneficiary access in awarding Medi-Cal contracts. Contrary to the widespread expectation that a limited number of hospitals would receive contracts, Guy explicitly stated a "desire to contract with every hospital possible."[12] Indeed, former GOSHN staff explained that they deliberately erred in the direction of excess bed capacity, not only to insure access to care, but also to have the flexibility to bargain with excess capacity in the second year of contracting.

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[12]W. J. Unger. Health Finance Monitor. "HFM Interview: William Guy - California Charts." December 1982, pp. 60-84.

Beneficiary access to care was insured further by the development of a community travel time standard. If any beneficiary resided further than the standard travel time for his or her community from a contract hospital, DHS would authorize care in the closest non-contract hospital. At GOSHN's request, DHS conducted a study to determine the travel patterns of beneficiaries. Historical travel times for inpatient services were calculated for each county and used by GOSHN in evaluating which hospitals to select as contractors. Using the standards and information on the distribution of beneficiaries in an area, GOSHN could evaluate whether the majority of patients resided within a reasonable geographic distance of contract hospitals.

Similarly, GOSHN was mandated to consider a hospital's "ability to render quality services efficiently and economically" in awarding Medi-Cal contracts. However, GOSHN did not see itself as an authority to evaluate quality of care, nor as a legal entity to enforce sanctions against providers not meeting quality standards. Since, according to GOSHN, the DHS Licensing and Certification Division maintains this responsibility, hospitals passing Licensing and Certification audits were considered as meeting the 14083 quality criteria. On the other hand, GOSHN did try to ensure that services were rendered equally among patients -- private and government payers alike. Thus, contract offers could not include provisions that segregated Medi-Cal patients from other patients in services, beds, or buildings.

The decision to reimburse hospitals on per diem basis was made on the grounds of expediency. The per diem was to be an "all-inclusive" rate including all general acute services (i.e, medical-surgical, obstetric, pediatric services). GOSHN's initial position was to reject a per diem that would allow exceptions for high-cost procedures. Psychiatric services, however, were generally excluded and offered at a separate rate, although there was

some confusion on this issue in the early weeks of negotiating. However, GOSHN staff claim that they never intended the per diem rate to be the unit of reimbursement forever. At the time, the priority was to identify a reimbursement method that was easy for the state to understand and administer. and required relatively little data to establish a given hospital's preferred contract rate.

The model contract further placed the hospital at risk through provisions specifying that the hospital was to assume responsibility for all services rendered to presenting Medi-Cal patients, regardless of the type of the service. That is, if a patient presented himself to the contract hospital and was referred to another hospital for specialized services, the originating hospital would be responsible for billing the state and reimbursing the receiving hospital. However, as will be described in Chapter 5, deviations from the model contract in this area became the norm, rather than the exception.

Specification of the geographic areas on which negotiations would be based was critical. Hospitals had to compete against each other in a given community or area in order to create the incentive to lower their bids. Some state data bases were organized by health facility planning areas (HFPAs), units used by HSA's to project bed need and review CON requests. DHS reorganized the necessary data into HFPA files and GOSHN analyzed historical Medi-Cal costs and utilization of hospitals within HFPA's, as well as comparing HFPA average costs and utilization relative to other HFPAs.

The proposed framework for the negotiation process was fairly simple. A letter of invitation to negotiate a Medi-Cal contract would be sent to every hospital in an HFPA. Hospitals returning the acceptance letter to participate would be invited to Sacramento for two meetings. The first meeting would consist of an orientation to Medi-Cal contracting in which

negotiations basically laid out the "rules of the game." The second meeting would be held several weeks later in which the hospital representative(s) would present their bid to one of the six GOSHN negotiators. The negotiator would ultimately present the bids from hospitals in each HFPA to Guy, the data manager, and the two assistants. Each hospital's bid would be compared to GOSHN's data base of historical costs. If a hospital's bid was too high, that hospital might have a chance to submit another bid. Only Guy would make the final decision as to who would receive contracts. Once the decisions on a particular HFPA were made, the negotiator would notify each hospital of the decision, while the Governor's office would issue press releases. An HFPA was considered to be "closed" after all the negotiations were finished. GOSHN tried to conclude negotiations with an HFPA within six weeks. However, as will be discussed in Chapters 4 and 5, the process was not always that straightforward.

The HFPA sequence in which negotiations would take place was also crucial. Anecdotes about the negotiation process circulating among hospitals would influence negotiations in other HFPAs. Acknowledging this potential learning curve among hospitals, Guy wanted to conduct the first phase of negotiations in HFPAs that would display "dramatic and decisive results."[13] Urban HFPAs with high concentrations of Medi-Cal patients and high percentages of historical Medi-Cal expenditures were selected to be the initial HFPAs in which to negotiate. Los Angeles, accounting for one of the highest historic Medi-Cal expenditures entered the negotiation process two months after observing a much publicized negotiation process in San Francisco.

San Francisco was the first HFPA to negotiate with GOSHN and the first HFPA to "close." The experience in San Francisco resounded throughout

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[13]Ibid.

the state, and other hospitals took notice. None of the three largest hospitals providing services to Medi-Cal patients were awarded contracts: St. Mary's, Mt. Zion, and the University of California at San Francisco (UCSF). Together, these three hospitals had historically provided about 40 percent of the Medi-Cal days in San Francisco.[14] As the first HFPA to "close," the exclusion of these three hospitals sent a powerful message to hospitals in other HFPAs: play GOSHN's game, or risk not getting a Medi-Cal contract.

After the first round of negotiations in San Francisco, negotiations in the remainder of the state went relatively smoothly. The remaining hospitals cautiously negotiated with GOSHN, and no other lawsuits or major complications arose. As of June 30, 1983, GOSHN had negotiated contracts with 245 hospitals in 65 HFPAs, representing 67 percent of the hospitals which had entered into negotiation and accounting for 85 percent of historic state Medi-Cal expenditures. GOSHN was unable to negotiate satisfactory agreements with hospitals in nine HFPA's, leaving these areas "open." Areas in which other cost-effective health systems were being tested were exempt from negotiations. By May 1983, GOSHN was able to estimate that $238.1 million would be saved in the Medi-Cal 1983-84 budget, based on a month-of-service cycle, and about $162.3 million, based on month-of-payment.[15]

CMAC appointments were made in late December of 1982. As specified in the legislation, Governor Brown appointed three commissioners, one of whom

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[14]In fact, St. Mary's and Mt. Zion hospitals brought lawsuits against the state claiming that the state had made "arbitrary and capricious" decisions. St. Mary's hospital obtained a restraining order preventing the state from excluding them from the Medi-Cal programs. To avoid a long and costly court battle, Guy "reopened" the San Francisco HFPA five months later. All acute care hospitals in San Francisco received a Medi-Cal contract during this second round of negotiations.

[15]As explained in Chapter 6, month-of-payment savings lag behind month-of-service savings because of the lag between when services are offered and when they are paid for.

was designated as the Chairman. The Speaker of the Assembly and the Senate Rules Committee appointed two commissioners each. The composition of the seven member CMAC resulted in a totally Democratic commission. The commission included health care specialists and lawyers, businessmen, a former Assemblyman and Congressman, and a physician.

During the six-month overlap in which CMAC and GOSHN coexisted, CMAC met once a month to monitor GOSHN activities. In June, CMAC met more often in preparation to take over selective contracting on July 1, 1983. According to AB 799, the Czar was allowed to become the Executive Director of CMAC. However, Guy, true to his earlier statements, retired to Maryland on July 1, 1983.

CHAPTER 3

STATE ORGANIZATIONAL ISSUES

Under normal circumstances, the legislature would have empowered the Department of Health Services (DHS), the single state agency responsible for administering Medi-Cal, with the task of negotiating the selective contracts with hospitals. However, legislators did not believe in the efficacy and efficiency of DHS, particularly given the exigencies of the fiscal crisis. They brought in an outsider and endowed him with tremendous discretionary powers and flexibility to carry out a specific mandate.

The creation of this special office with virtually no legislative or state accountability poses several questions.

- Was it necessary to create a special office with extraordinary powers to implement hospital contracting?
- What was the relationship between the administering agency (DHS) and the negotiating agency (GOSHN)?
- What adaptations did DHS have to make to accomodate GOSHN? and,
- And, what existing structures, if any, supported hospital contracting?

This section examines each of these questions.

3.1 Necessity of Special Office

The need to create a special office to negotiate contracts was virtually unquestioned by respondents. Contracting with hospitals to provide services to Medi-Cal recipients had never been attempted. The unique nature of contracting required, respondents felt, special attention and staff. However, the need to place the special office outside DHS was disputed by several respondents. Similarly, some observers questioned the necessity to endow the special negotiator with extraordinary protection against legal review and public disclosure.

The concept of the "special negotiator" was a response to the legislature's frustration with bureaucratic implementation delays. As described in the previous chapter, the Director of DHS publicly announced that implementation of contracting by the Department would take three years. But the Legislature needed a "quick fix" in order to balance the 1982-1983 budget. Thus, a special negotiator with complete authority, and located outside DHS, was established to direct the negotiations.

This approach was unprecedented, but most respondents believed that the only way to achieve rapid savings through contracting was to give one person total command over the negotiation process. As one former GOSHN negotiator said:

> DHS's attitude is to study something forever and then implement it...If it had been up to DHS, they would still be thinking about how to implement contracting.

DHS delays, respondents suggested, could have resulted from the necessity of securing consensus among its various bureaus and divisions. Several DHS staff disagreed with this position claiming that the department could have accomplished the goal without delays. However, others felt that the department would have been "at war with itself," as a former DHS staff member put it.

Despite the general pessimism, a few respondents thought that a special office within DHS could have implemented hospital contracting. While in the minority, these respondents cited one advantage of a special office within DHS: the friction between DHS and GOSHN could have been avoided. On the other hand, few could imagine Mr. Guy working for the DHS Director.

A somewhat larger number of respondents felt that it did not make sense to separate the Medi-Cal administration and contracting functions indefinitely. The respondents argued the reason for separating the functions

in the first place, to implement contracting quickly, had been satisfied. DHS staff also expressed what was essentially a proprietary concern that responsibility for negotiating hospital contracts should rest with the Medi-Cal administering agency. These respondents recommended that once GOSHN's tenure expired and contracting had been set up, the negotiating functions could have been handed over to a special unit within DHS.

The cloak of secrecy surrounding the negotiation process was also questioned by many respondents. The Czar's exemption from public scrutiny of the rates, terms, or conditions of any contracts, coupled with the protection against disclosure of GOSHN's criteria for decisions, created a mystique about the negotiation process. Many hospital administrators made a distinction between the need for secrecy about the negotiated contract rates and the terms of the contract. They generally accepted that to stimulate competition the negotiated rates should not be disclosed. On the other hand, they did not see the need to keep the terms and conditions of the contract confidential. According to these respondents, not knowing which hospitals had contracted to provide certain services caused enormous transfer and referral problems.[1] Similarly, financial responsibility for transfer cases became clouded because hospitals were not allowed to disclose the terms of their contracts relating to service provisions. GOSHN staff acknowledged these difficulties, but maintained that at least for the first year of contracting, GOSHN needed all the leverage it could get and not having people know the contract terms was an advantage.

Another issue related to the special powers of the Czar is the

[1]As a practical matter, most hospitals know what services neighboring hospitals provide, so merely knowing whether or not a hospital was a contracting hospital would almost be sufficient since hospitals always contracted for all services they provide.

question of whether contracting could have been implemented by someone other than William Guy. Certainly administrative flexibility alone was not sufficient to implement contracting: Other conditions also were necessary for the Czar's success. First and foremost, the Czar, being in a sensitive and powerful position, would have to be immune from political pressure. Second, he would have to be an executive capable of making decisions with limited information. Third, the respect of the health care industry and the confidence of the legislature would be necessary to provide a sense of security in this time of uncertainty. Finally, a "vision" of the health care system was necessary to guide his actions.

Respondents agreed that Guy had these four characteristics. That he also had a natural gift of charismatic leadership, as well as hospital contracting experience, was a bonus. Indeed, while it cannot be determined whether Mr. Guy was indispensible, it can be said with certainty that he contributed to the successful implementation.

3.2 Relationship Between GOSHN and DHS

The relationship between DHS and GOSHN was inherently awkward. By creating an outside agency to negotiate the contracts, the legislature had implicitly indicted DHS. Differences in agency objectives and roles also contributed to the tension. As the state's administering agency and only signer of the contracts, DHS had a vested interest in ensuring that the negotiated contract terms were capable of being operationalized. GOSHN's goal was to negotiate terms and rates that would achieve target savings. Negotiators would often face a trade-off between achieving a lower rate and negotiating contract terms that would be difficult, if not impossible, for DHS to implement. Slowly, this problem was worked out. As one DHS staff put it,

learning was evolutionary.

> The negotiators stopped making certain mistakes, and we (DHS) stopped asking for certain provisions.

DHS was entirely excluded from the direct negotiations with hospitals. Nevertheless, DHS's signature on the contracts committed the state to the specified rates and terms. When GOSHN drafted the model contract, DHS was anxious to review it. Despite DHS's concern, GOSHN was reluctant to have DHS participate in the preparation of the model contract. Several DHS staff members remarked that Guy did not want the negotiators to talk to DHS at all. Eventually, DHS had to review the contracts in order to sign them. Consequently, during the first wave of contracting, DHS demanded that several items be changed in the model contract before the DHS Director would sign the contracts. The changes included: refining the definition of inpatient services so that a hospital's liability for some portion of transportation, outpatient, and emergency services rendered prior to admission was included in the rate; easing the requirement that hospitals take action against medical staff who violate the Medical Staff Bylaws; eliminating payment for "administrative days"; and, eliminating clauses that restricted the Medi-Cal Operations Division Chief's ability to interpret the contracts.

Another issue that disturbed DHS was the lack of standardization among the contracts. While the model contract served as a starting point, the number and type of variations in contract terms achieved by the end of the negotiation process was illuminating. As a DHS respondent said, "The contracts are not the creatures that people think they are." DHS encouraged the negotiators to negotiate consistent language and terms, but did not feel they were successful. There were at least five major departures from the standard contract:

(1) Most hospitals did not assume responsibility for all inpatient

services--responsibility was limited to services normally provided at the given hospital. (This variation became the rule, rather than the exception. Thus, each contract was different.)

(2) Several hospitals negotiated two per diem rates, one for general acute services and the other for intensive neonatal care, psychiatric care, or other special services.

(3) Some hospitals negotiated separate rates based on the number of Medi-Cal patient days provided--for instance, a lower rate for patient days over a certain threshold.

(4) Some hospitals negotiated capacity limits based on available beds or other capacity related factors (These were primarily attempts at defining when the hospital was "full".)

(5) Some hospitals negotiated requirements that beneficiaries could not be admitted by physicians without admitting privileges at that hospital.

These deviations from the model contract allowed hospitals to control their costs and at the same time mitigate their fear of patient "dumping" or becoming a "Medi-Cal hospital."

The most critical issue dividing GOSHN and DHS was the format of Appendix A of the contract. The intent of Appendix A was to specify the services excluded from the negotiated contract. Initially, Appendix A was a narrative summary of the excluded services. However, the ambiguities inherent in the text led DHS to request an explicit list of excluded services. As a result, Appendix A also lists the billing codes for excluded services (i.e. those codes not billable by the individual hospital).

Many providers in the first wave signed their contracts before these billing codes had been filled in. The Director of DHS, on the advice of her attorneys, refused to sign any hospital contracts unless these billing codes were complete. The intermediary was not set up to reimburse providers on a narrative basis. However, GOSHN did not see the need for the delay. The disagreement over Appendix A erupted in front of Governor Brown immediately before his departure from office in December. The Governor, anticipating an

announcement of contract implementation as one of his last acts in office, threatened to fire the DHS Director if she did not sign the contracts. However, his own counsel advised him that the DHS Director was correct in suggesting a delay in implementation. The dispute between DHS and GOSHN over Appendix A delayed the contract effective date from January 1, as originally planned, to February 1, 1983 as DHS advocated.

Despite these difficulties and the one month delay, GOSHN and DHS completed all the tasks required to implement hospital contracting. Indeed, DHS cooperated in providing GOSHN with hospital-level data on historical costs and utilization; an agreement about the model contract was reached; a contract review and management monitoring system was established; and so forth. So, even though there was a certain level of inter-agency friction, it did not prevent the significant accomplishment of implementing contracting in a very short time period.

3.3 Organizational and Procedural Changes in DHS

As mentioned previously, AB 799 accorded DHS the responsibility of signing each hospital contract, thereby committing the state to the specified rates and terms. However, the DHS Director's signature represented more than the state's agreement with the contract. It also represented a commitment to monitor hospitals' compliance with their contracts. Establishing the mechanisms to sign and monitor hospital contracts required a number of organizational and procedural adaptations.

Seven divisions within DHS and the Department of Finance reviewed the proposed hospital contracts for the DHS Director's signature during the first round of negotiations. The DHS divisions included Audits and Investigations, Licensing and Certification, Policy and Procedures,

Operations, Fiscal Intermediary Management, Administration, and Legal. Given the pressure to implement hospital contracting as soon as possible, GOSHN allocated five days per contract during which DHS was to solicit comments from all seven divisions and incorporate the changes into the contract. Although this new review function was assigned to these divisions, no new staff were added to assist the process.

The Legal Division was the hub of all the activity. Four lawyers were assigned to processing the contracts. The proposed contract was circulated among the divisions for their comments before Legal rewrote the contract. However, it did not take long to figure out that circulating the contracts among six other Divisions could not be done within the five day limit. The Legal Division hired runners to run between departments which helped to speed up the process. The proposed contracts, along with each Division's comments, were returned to the Legal staff members assigned to contracting who rewrote and modified the contracts. More often than not, the five day review process turned into three hectic days in which comments were solicited and the contract was modified. It was a "wild and wooly period," to use the words of one DHS respondent. Still, 245 hospital contracts were negotiated, reviewed and signed within six months.

Once all the contracts were negotiated, overall responsibility for the hospital contract administration and monitoring passed from the Medi-Cal Legal Division to the Operations Division within DHS. Contract monitoring produced new duties for some divisions within DHS including developing a beneficiary grievance and provider audit system, adjusting the claims processing system, and creating a method to communicate with recipients, hospitals, and physicians. The Hospital Contracts Coordination Unit (HCCU) was created within the Operations Division with responsibility for the

grievance and audit system. The Fiscal Intermediary Management Division (FIMD) within DHS handled the oversight functions for changes to the claims processing system. Recipient notification of changes was handled by the Policy and Procedures Division. Similarly, an ongoing notification system with hospitals and physicians was initiated by HCCU.

DHS monitors client grievances and complaints through the Beneficiary Complaint System. First, contract hospitals are required to establish a patient grievance system and to give Medi-Cal patients a questionnaire about their satisfaction with the care they received. These questionnaires are also monitored by HCCU. According to DHS, the volume of grievances is low--only about 25 complaints had been received by the end of the first year of contracting. Most of the grievances relate to the patient's perception of personal treatment rather than to the quality of care. For example, patients would complain about physician rudeness or hospital housekeeping and food services rather than complaining about the effectiveness of the procedures or treatments. Many hospitals reported response rates less than ten percent on the questionnaires. Thus, reliance on beneficiary input makes it difficult to evaluate patients' satisfaction with their medical treatment under the contracting program.

A more useful mechanism for monitoring quality of care is the Incident Report System. Incident reports are routinely completed by units within DHS who handle complaints from beneficiaries and providers. In addition, any individual, including patients, hospital staff, or Medi-Cal field office personnel, can file an incident report. The types of incidents that are reported typically involve:

- Admission delays or denials;
- Treatment and transfer concerns relating to emergency room treatment in a contract facility and transferring the patient to

another hospital for admission;

- Transfer concerns related to moving a Medi-Cal patient from one facility to another after the patient has been admitted on an inpatient basis;
- Physician privilege concerns in which a physician is unable to admit Medi-Cal patients to contract hospitals;
- Emergency service availability and/or delivery;
- Appropriate service concerns related to emergency transportation from patient pickup to arrival at the hospital;
- Quality of care concerns relating to incomplete or unsatisfactory delivery of services.

Most incidents can be quickly resolved by the Medi-Cal Field Office, although both resolved and unresolved incidents are reported to HCCU to be recorded and reviewed. A Medi-Cal Consultant reviews all complaints and makes an initial referral. For example, quality of care concerns are referred to the Licensing and Certification Division. Similarly, complaints regarding medical benefits are sent to the Medi-Cal Benefits Branch. As a result of the reviews, incidents are then categorized into three groups:

1) Non-incidents in which the facility activity is deemed appropriate and within the limits of the Medi-Cal model contract;
2) Negotiated contract incidents in which the reported event is deemed appropriate as a result of increased risk-bearing deviation from the model contract; and,
3) Contract violations in which the event is "clearly and specifically disallowed under the terms and conditions of the negotiated special hospital contract."

If contract violations are identified, the facility is issued a "warning letter" in which the facility is informed that it faces possible contract sanctions. However, the sanctions are limited. The first of the available sanctions is to cut off the hospital's cash flow. If the facility continues to disregard the contract violation, the DHS has only one choice--to terminate the hospital's Medi-Cal contract.[2]

DHS contends that most of the "non-incidents" stem from confusion about the proper role of transferring, particularly about what services are included in contracts. As far as transfer problems, many people remain confused by the original model contract which intended that hospitals would be responsible for patients transferred to another hospital. Once some hospitals were allowed to transfer patients to other hospitals without incurring financial responsibility, charges of "dumping" became common. There was also genuine confusion among hospitals as to who had the fiscal responsibility for certain patients. DHS gave this example of how an incident report turns out to be a non-incident:

> A contract hospital transfers a patient to another facility. The contract hospital asserts it is not contractually responsible for the continued care of the patient because the required services are excluded from its contract. The receiving hospital (which does not know the contents of the transferring hospital's contract) requests clarification from the local Medi-Cal Field Office to determine what authorizations for treatment should be obtained. The Field Office staff intervenes to interpret the contract and instructs the receiving hospital on how to seek reimbursement, that is, either from DHS because the contract hospital correctly interpreted its contents or the contract hospital maintains ongoing responsibility for the patient's care.

As is obvious from the above, the confidentiality of the contracts adds to the confusion.[3]

Contracting also required substantial modification of the state's claims processing system. The claims processing system is contracted out to a fiscal agent, Computer Sciences Corporation (CSC). When hospital contracting was implemented, CSC had to adjust the claims system to reflect each hospital's negotiated contract. FIMD monitored CSC's design and implementation of

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[2]Incident reports and resolution of the incident reports are discussed further in Chapter 7.

[3]As discussed in Chapter 9, after the initial phase-in, hospitals have found transferring problems much more manageable.

these change orders. Designing and implementing the changes to accommodate differences in each hospital's contract was not trivial.

Flagging contract hospitals was the easiest part of the task. Handling multiple rates was considerably more difficult, since rates varied on a number of dimensions for different hospitals. In some cases the rates varied by type service (e.g., Med/Surg, Psych or Neo-natal). In other cases, the determination of a rate for a particular bill depended on having accumulated information on all previous bills, (e.g., a hospital received a different rate after it had provided 8000 days of Medi-Cal care.)

Appendix A also presented problems. Because some hospitals were required to pay for all services, while other hospitals had a list of excluded services, it was necessary to evaluate each claim against the list of excluded services. At first, as mentioned earlier, there was an attempt by GOSHN to identify the list of excluded services from a narrative statement developed by GOSHN and the hospital. The intermediary was unable to develop the list of excluded services from the narrative statement, which was one of the reasons that DHS Director Beverlee Myers refused to sign the contracts.

Physician services were also problematic since some hospitals included physician services in their rates and other hospitals did not. Claims for physicans services, therefore, had to be reviewed on a hospital-by-hospital basis. Appendix A, therefore, also included a list of physician procedures which were included in the contract. . If the negotiated hospital rate included certain physician procedures, attempts by a physician to bill separately for those procedures would result in a rejection of the physician claim. There was quite a bit of confusion among physicians, hospitals and GOSHN as to what physician services were included or excluded in the hospital rate. DHS reports that many physicians were completely confused when their

claims were rejected. Either some hospitals had not informed the physicians or the physicians had not paid attention to the change in billing procedures.[4]

CSC was given only three months to design, develop, and implement the reimbursement changes orders, at the cost of $250,000. Additional operating costs were close to $964,000 annually. To say the least, CSC and FIMD found themselves in a quagmire of operational problems. At first, there were a series of system change orders. But GOSHN negotiators would often fail to consult with FIMD staff on the feasibility of translating language negotiated with individual hospitals into system logic. Often, for example, CSC was unable to identify whether particular services were included in the rate. As a result, many claims were temporarily suspended until the ambiguity in service exclusions were clarified in Appendix A.

Not only were there operational problems, but there were also user problems. The most common problem resulted because contracting hospitals were given a new provider identification (ID) number for services offered under the negotiated per diem. The old provider ID, however, was still used for services prior to or not included in the contract rate. Claims were often submitted with the incorrect ID. These claims were also temporarily suspended until new edits and screens were in place to correct the IDs. Over time and with experience, CSC and FIMD refined the system so that it operated more efficiently and smoothly.

The issue of recipient notification was another matter faced by DHS. Prior to hospital contract implementation, the Policies and Procedures Division mailed a brief flyer to each Medi-Cal recipient describing the

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[4]One of the most common matters addressed by CMAC in the latter half of 1983 was cleaning up physician related issues; however, these had been further confused by the TEFRA requirements for unbundling of physician services.

impending changes. Respondents--both within and outside DHS--uniformly agreed that these notices caused more client confusion than clarification. DHS decided, therefore, to let physicians inform their Medi-Cal patients of which hospitals were participating in the Medi-Cal program. It was felt that the physicians would be more effective in notifying clients of the impending changes in hospital status, since physicians play such a major role in client hospital selection. In large part this was simply recognition of the fact that the concept of being "locked out" of a hospital within an area called an HFPA would not be meaningful to clients.

In addition to communicating with recipients and physicians, hospitals needed clarification and notification of ongoing issues. The Hospital Contracts Coordination Unit was established within the Operations Division to receive calls from hospitals to clarify contract language, settle delegation issues, and so forth. This unit, consisting of four professional staff, maintains the central contractual file and answers questions about contract interpretation from hospitals, physicians, field office personnel, clients and others. Most of the questions from providers concerned claims payment problems or medical necessity issues. In addition to fielding questions for immediate resolution, DHS conceived of a "Hospital Contract Letter" series to be sent to all contract hospitals, notifying providers of ongoing developments, but DHS had difficulty finding time to get out these newsletters on a regular basis.

3.4 Prior Authorization System

A critical feature of implementing hospital contracting was the state's prior authorization system. While not an organizational adaptation to contracting, the prior approval process was a fundamental structure supporting

hospital contracting. There is a serious question as to whether contracting on a per diem basis could have succeeded without this system.

Under a per diem rate, a financial incentive is created for hospitals to increase their revenues by extending a patient's length of stay. Had the prior authorization process not been in place, hospitals may have been tempted by this potential loophole. However, given that the prior approval system maintained such a tight control on the number of inpatient days, GOSHN could proceed with relative confidence that such abuse was unlikely to occur.

The prior approval system was implemented in 1967 in an effort to reduce unnecessary procedures and to control extended hospital stays. Treatment Authorization Requests (TARS) are submitted by each hospital to their local Field Office before any procedure or service can be delivered to a Medi-Cal patient. Emergency services are reviewed on a post service basis. If medically justified and documented, the emergency procedure is authorized. Requests to transfer a Medi-Cal patient to another hospital for special procedures also have to be submitted. Local Medi-Cal consultants review each TAR to approve the treatment as well as the number of inpatient days. Unless proper and complete documentation accompanies the TAR, the hospital is denied payment. Claims are not processed by the fiscal intermediary until the local Medi-Cal office approves each TAR. Through the years, this system has been tightened by bringing more services under its purview, by limiting the number of automatic approvals, and by gradually reducing the number of days allowed for various services.

Hospital contracting, in and of itself, minimally affected the prior authorization process. There were a few initial problems, some of which were resolved and others that persist. However, some Medi-Cal Field Office staff actually argued that contracting improved their ability to detect "patient

dumping" incidents. To understand this improvement, it is first necessary to describe how transfers are handled by the field offices under contracting.

Under contracting, transfer requests are approved only if the procedure is one of the excluded services listed in Appendix A of the originating hospital's contract. In such a case, the receiving hospital is responsible for billing the state. However, a transfer might be a "delegation" if the service is not excluded by the originating hospital's contract, but the originating hospital cannot provide the service (either because their beds are full, or because the originating hospital does not provide the service even though it is not listed in Appendix A). In the case of a delegation, the originating hospital is responsible for billing the state.

Transfers for services not excluded by Appendix A potentially include those cases that are economically attractive to "dump" onto another hospital. For example, a high risk and complicated Medi-Cal case requiring a high degree of the hospital's resources is more likely to be "dumped" onto another hosital than a case needing less intensive care. Similarly, some Medi-Cal patients may be re-routed to another hospital because beds filled with private payers are reimbursed at higher rates than beds filled with Medi-Cal patients. Field office nurses pay close attention to each transfer request to insure that "dumping" does not occur.

Prior to contracting, field office nurses reviewed transfers, but not with the same intensity as under contracting. For each transfer request, the field office examines the Emergency Room and Transportation Logs at both the originating and receiving hospitals, whereas previously, that log review was periodic. As a result, field office staff felt that they were better able to identify cases that are "dumped" onto another hosital.

Approval of transfer requests (and subsequent assignment of payer responsibility) requires familiarity with each hospital's contract, particularly the excluded services in Appendix A. It is therefore surprising that the field offices did not have copies of the contracts when contracting went into effect. This created some confusion about how to deal with early transfer requests. Ultimately, the contracts were delivered to the field offices and review of transfer cases became somewhat routine, although the ambiguity in Appendix A continues to present confusion. One field office administrator explained:

> It is still difficult to figure out which hospital is responsible for specific services. We still get some cases where we think one hospital is responsible, but then a lawyer will find a phrase in the contract and the hospital won't be responsible.

While hospital contracting did not dramatically change the prior authorization process, the change in the definition of medical necessity did. Language adopted by AB 799 redefined "medical necessity" for care under Medi-Cal to only include services necessary "to protect life or prevent significant disability." Thus, TAR criteria for approving particular treatments was seriously narrowed. The change made it more difficult for Medi-Cal patients to obtain elective services.

To implement the new definition of medical necessity, DHS developed five lists identifying allowable procedures. Medi-Cal field offices were to use these lists in approving TARS. The first list included procedures that were automatically denied and if challenged, rarely approved. The second list included procedures generally considered to be elective and were only approved if the procedure met the "life and disability" test or the other criteria. The third list covered surgical procedures requiring prior authorization. The fourth list included procedures often done in inpatient settings but now reimbursable only on an ambulatory basis. Finally, the fifth list covered

common office procedures that would be reimbursed at only 80 percent of the previous Medi-Cal allowance.

Criteria for approving the number of patient days was not as clearly spelled out as the lists for allowable procedures. Formally, field office staff use a manual that cites a standard number of inpatient days by type of diagnosis. However, in practice, field office nurses exercise some latitude in approving days for procedures. Approvals for length of stay tend to be more flexible than approvals for treatments.

Provider reaction to the tightening of the prior approval process was mixed. Most hospitals and the California Medical Association (CMA) believe that the state should provide safeguards against unnecessary utilization. However, CMA claims that:

> Specific circumstances for individual patients are unique and prior authorization requirements should not be interpreted arbitrarily. When there is doubt as to the medical necessity, this question should be resolved in favor of the patient and his or her attending physician.[5]

Testimony by providers and individual Medi-Cal recipients before the Assembly Committee on Health in October 1983 cite several cases in which TARs were denied because they were not necessary to prevent death or disability, but nonetheless were a medical necessity. For example, one physician presented this case:

> A diabetic was seen in the emergency room one Saturday with a fractured jaw that was terribly swollen. He was sent home over the weekend to put ice on his jaw so that he could be admitted on Monday, his diabetes controlled, and his jaw wired on Tuesday. When he came in on Monday, a TAR was not submitted because the physician was under the impression that this was an urgent emergency case that didn't need a TAR. The admission was denied because the TAR was not submitted on Monday; however, Tuesday's care was covered because the review nurse for Medi-Cal was already in the hospital and saw the

[5]Assembly Committee on Health Interim Hearings, "Prior Authorization and Medical Necessity," October 4,1983.

> case and approved the second day of his stay. That's a situation where the TAR process really interferes with the care that everyone would agree would be necessary. There's no question that someone with a fractured jaw with diabetes needs to be in the hospital.[6]

In addition to the ambiguity over the definition of a medical necessity, hospital revenues are affected. In the above example, since a portion of TAR was denied, the patient would theoretically have to pay the bill. However Medi-Cal patients usually do not have the money and thus the disallowed costs are added to the hospital's charity care.

A review of records kept by two field offices indicated that between five and eight percent of all inpatient days are disapproved by the TAR process. This figure represents only days of care actually provided and subsequently denied. It does not include days which the hospital did not provide because the field office indicated it would not approve additional days for a patient. On the other hand, this percentage includes an unknown number of days which are later approved on appeal. Clearly, the prior authorization process has a substantial impact on hospital revenues and administrative procedures.

In addition, respondents felt that the prior authorization process added to patient fears about seeking services. These respondents felt that patients, fearing rejection, are reluctant to seek medical services. Concerns about the long run effect of postponing medical care were expressed.

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[6]Ibid.

CHAPTER 4

BIDDING PROCESS: STATE PERSPECTIVE

GOSHN was proceeding under two general constraints: the legislative mandate to achieve savings of about $200 million in Medi-Cal inpatient expenditure at the same time as satisfying Section 14083 provisions of AB 799 regarding the implementation of contracting. GOSHN's first problem was to identify a construct which lent itself to operationalizing both sets of constraints.

As mentioned earlier, the fundamental building block of this construct was the Health Facility Planning Area (HFPA), a subdivision of HSAs determined by the State Health Planning Council to approximate specific health market areas. Savings targets were allocated to each HFPA based on its share of historic Medi-Cal utilization. Bids were then collected on an HFPA by HFPA basis. When all of the final offers were submitted by hospitals in an HFPA, they were evaluated collectively against the savings target for that HFPA and against the 14083 factors. No contracts were awarded in a given HFPA until the savings target had been met and the 14083 conditions satisfied. However, once both these conditions were satisfied, the HFPA was "closed", negotiations were ended, and contracts awarded to the winners.

The following sections address the general tactical and negotiating problems encountered by GOSHN. Sections also address specific lessons learned from the San Francisco experience and issues in the rest of the state.

4.1 Tactical Considerations

The strategy of contracting for hospital services seems intuitively clear. But, like many other strategies, once one actually begins to implement, many more issues must be confronted than originally imagined. This section ennumerates these issues and discusses GOSHN's approach to them. Included in this section are discussions of the tactical considerations underlying the basic bidding format, the problem of forecasting expenditures by HFPA, access and other quality concerns, and the political factors which enter into any major change.

4.1.1 Conceptual Models

If one is to achieve a given savings through contracting with hospitals there are two theoretical approaches: one can contract primarily with those hospitals with historically lower rates or one can use contracting as a lever to induce a wide spectrum of hospitals to lower their rates. It appears that GOSHN favored the latter strategy from the beginning. In an August 16 interview, before California had even received a waiver from the federal government and several months before contracting started, William Guy stated:[1]

> GUY: It is not my desire to contract with as few hospitals as possible. It's my desire to contract with every hospital possible. That's 600.
>
> INTERVIEWER: You think you can cut costs by contracting with every hospital?
>
> GUY: There's no question in my mind I can.

[1] LACMA Physician: Bulletin of the Los Angeles County Medical Society; September 20, 1982; p. 24.

There are several reasons why Guy might have favored such an approach. The most general is that such an approach minimizes disruption. The more Medi-Cal recipients who must move from one institution to another, the more press, the more political complaints, the more administrative monitoring necessary and so forth. Moreover, Guy may have suspected that it would be difficult to convince many hospitals to drastically increase their Medi-Cal load for fear of being identified as a "Medi-Cal" hospital or a "charity" hospital with resulting adverse effects on private patient census. He also may have realized that contracting with a larger number of hospitals would avoid problems in compliance with the Section 14.083 constraints.

On the other hand, contracting with a large number of providers creates a major tactical problem: if hospitals believe that the state will contract with all of them, hospital motivations to submit low bids are undermined. So whatever Guy's general predilections may have been going into the contracting process, he must also have understood that flexibility was the key during the first round. Flexibility was certainly the message received by the negotiators. One former negotiator said:

> You have to keep in mind that we had no idea what would happen in the first HFPA. We didn't know if we would receive any bids, or if we would hit any savings targets. It was a complete unknown. We didn't know whether hospitals would believe us. We didn't even know if we believed ourselves.

Thus, while Guy and his staff were disposed to contract with as many hospitals as possible, they were not locked into any particular direction.

A second major issue faced by GOSHN was how to structure the elements of the initial bid. GOSHN's main approach concentrated on reducing as much as possible the elements on which bids could vary. Hospitals were directed to structure bids on three main assumptions:

- All inclusive per diems as the unit of reimbursement;

- Financial responsibility for all services needed by a presenting recipient, even for services which that hospital did not offer; and
- No specification of the volume of services to be given as part of the contract.

Each of these aspects of the bidding elements had tactical implications which deserve further consideration.

One of the early key decisions made by GOSHN was the decision to encourage bidding on a per diem basis. Encourage is apparently a very mild word for GOSHN's attitude. Only two contracts were signed on bases other than per diems. Most of our hospital respondents had at least discussed some rates on other than a per diem basis. However, all respondents reported that they had been discouraged from pursuing bids on other than a per diem basis and, indeed, had the impression that a final bid in other than a per diem form was a serious impediment to receiving a contract.

Virtually all respondents--hospital or state--who commented on this issue claimed that the per diem choice was made because of the relative ease of administering per diems. Guy himself apparently indicated that he favored discharge rates but did not have time to develop them. GOSHN respondents agreed about the administrative simplicity of using per diems, but also added that Guy did not want to be at risk for changes in length of stay.

GOSHN judged that a per diem system was easier to administer than a per discharge system when it became apparent that the historic discharge rates were not as reliable as the historic per diems.[2] GOSHN was also concerned

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[2]DHS and their fiscal intermediaries have had difficulty producing accurate counts of discharges. In part, this is because the concept is inherently more complicated than days of care (i.e., how many discharges are incurred by a transferred patient?) and in part, because the computer programming for partial-stay claims and for incorporating adjustment claims results in unstable discharge counts. It is somewhat surprising that this problem would be so severe since prior to contracting DHS had been using--and

that case-mix adjustments (e.g., DRGs) would need to be calculated if a per-discharge system were used. It must be remembered that GOSHN was a response to a particular budget crisis. Additional loss of time made it less likely that they would meet their target savings for the year. Speed, in terms of weeks and even days, was paramount. Any approach which might slow down the implementation of contracting was viewed with great disfavor.

Comments about wanting hospitals to bear the risk for changes in length of stay are somewhat puzzling. In theory, a per diem system does precisely the opposite: it puts the state at risk for increases in length of stay. Setting aside the question of the state's Prior Approval System, a change toward a more severe case mix would probably increase length- of-stay which would then get reimbursed under a per diem approach. Only if one believed that the Prior Approval System could continue to whittle days off lengths-of-stay or that the patient mix would become less severe is it possible to assert that this approach reduced the state's risk for changes in length of stay.

In any event, it is clear that the decision to use a per diem basis would not have been plausible without the existence of the prior approval process to prevent increases in length-of-stay. The fact that length-of-stay continued to decline, even after the removal of cases no longer considered "medically necessary," is a strong testimony to the efficacy of California's utilization approval system.

The preference for a single, all-inclusive per diem is much more readily understood. DHS and GOSHN believed that a multiple per diem method related to the unit in which the care was rendered (e.g., neonatal nursery,

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continues to use for noncontracting hospitals--a reimbursement system based on discharge limits.

ICU, CCU) would make it easier to compare bids among hospitals. But they felt a multiple per diem system would be impossible to administer, since it would require a determination that services were in fact offered in that area for which the bill was submitted and that the services needed to have been offered in that area, as opposed to some less costly unit. Moreover, the use of multiple per diems put the state at greater risk in the event of major shifts in the case mix of the Medi-Cal population. Nevertheless, GOSHN apparently found it more palatable to compromise on this issue than on discharge-based reimbursement--about twenty hospitals had multiple perdiem rates based on services.[3]

Another major aspect of the bidding format, requesting that hospitals assume complete financial responsibility for all presenting recipients, obviously simplifies the process of evaluating bids. First, it theoretically makes all bids comparable since each bid must contain contingencies for all possible service variations. Second, it minimizes the problem of assuring access to specific services. If hospitals have responsibility for guaranteeing all services, GOSHN would not have to worry about contracting for specific service coverages. The latter would greatly increase GOSHN's contracting flexibility.

As it turned out, hospitals were either unwilling to bid on this basis or their bids were exorbitantly expensive. For the same reasons this approach would have simplified the evaluation of bids, it made it difficult for hospitals to prepare a bid. Under this conception, a hospital would be

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[3]Only six of these hospitals negotiated separate rates for services other than psychiatric services. However, GOSHN stopped contracting for psychiatric services after the first phase of contracting.

required to become a mini-HMO. Hospitals were not familiar or experienced with delivering services they generally did not provide. As a result, hospitals balked at the request and, in fact, very few contracts were signed in which the hospital assumed responsibility for all services for presenting patients. As discussed in the previous chapter, most contracts contain an appendix listing services which are not included in the contractual responsibility of the hospital. Those hospitals which submitted bids for all services, proposed higher rates for those services that the hospital generally did not provide. Eventually, those services were usually listed in Appendix A and the hospital would not be responsible for them.

The decision to not contract for specific volumes was made very early on and it is unclear if contracting for specified volumes was ever seriously considered. If such a course were pursued, the problems of estimating the impact from various contractual configurations would have been simplified. On the other hand, new problems would have been created. For example, an entire other area would have been opened for negotiation. Additional time might have been required; there may also have been a loss of leverage against price. Certainly an overall loss of flexibility in the bidding process would have resulted due to negotiating specific volume estimates. Specified volumes would also be difficult to administer. What would happen if volumes were more or less than the contracted amount? Would this increase hospital skimming behavior? How would hospitals prorate patients across the year? And so on.

The open-ended nature of the contract caused much concern among hospitals and certainly made their job of preparing bids more difficult. On the one hand hospitals had no way of estimating what volume they should assume in preparing their bid. Many hospitals were concerned about being swamped

with Medi-Cal recipients which they felt would have adversely affected their volume of better paying private patients. Attempts by hospitals to limit Medi-Cal exposure arose in many contract negotations.

4.1.2 Modeling HFPAs

Once the above general bidding mechanisms were defined, GOSHN's next step was to assemble a data base to guide contracting decisions. This data base included hospital capacity, historic Medi-Cal utilization, and historic Medi-Cal rates. As important as the data itself was the ability to interface the data with bid information in order to simulate possible outcomes.

Awarding a contract was not as simple as one might imagine. It was certainly not possible to think about the contracts solely in terms of individual institutions. Rather it was rather necessary to evaluate each contract bid in terms of its impact on the overall HFPA. Since HFPAs were the basic building blocks of the contracting process, it was necessary to model each HFPA before making the final awards in that HFPA.

The first step in modeling the HFPA flowed out of the tactical decision to avoid contracting with hospitals for individual services. Since there were to be no individual service contracts, GOSHN was forced to contract with the hospitals providing necessary services. Thus, the first step was to determine what individual services needed to be covered and in what quantity. (Individual services include such areas as ICUs, maternity services and Level II and III neonatal centers.) Once the needs had been identified, the least expensive configuration of hospitals which would give GOSHN sufficient service coverage was determined. As a result of these considerations, preliminary decisions were made about the hospitals which in some sense "had" to receive contracts.[4]

The next step in modeling the HFPA was factoring in the historic distribution of Medi-Cal patients within an HFPA, particularly at county hospitals. The role of historic patient distribution in evaluating the bids was not explicit. However, there was a general desire to minimize disruption by moving large volumes of patients. There was considerable concern among private hospitals that if only a few received contracts, they would be characterized as "Medi-Cal" hospitals. Many hospitals sought explicit guarantees in their contract about maximum numbers of Medi-Cal recipients or provisions where their contract was contingent on certain other hospitals receiving contracts. For instance, in several HFPAs, hospitals sought to include provisions that their bid was contingent on the county hospital receiving a contract. In other HFPAs, hospitals sought to make contract rates contingent on the total number of hospitals receiving contracts. Conversely, county hospitals depended so heavily on Medi-Cal it was difficult to imagine not awarding them a contract both because of the potential impact on the county hospital and because it was difficult to imagine to where that number of patients could be moved.

As it turned out, bids from hospitals which provided needed services or which historically cared for large portions of the HFPA's Medi-Cal patients were frequently higher than the bids submitted by other hospitals in the HFPA. Often this was because these hospitals had more complex case mixes--because they were providing certain services which were not widely available the general community. Consequently, even if these hospitals had sufficient capacity to absorb the entire Medi-Cal capacity for the HFPA, it would still

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[4]However, discussions with hospital and other respondents suggested that while the attention to covering necessary services was a key aprt of the decision, guidelines were stretched a little to close some HFPAs. For instance, it was occasionally necessary to assume that some services would be provided by adjacent HFPAs.

be to GOSHN's advantage to contract with additional hospitals with lower rates. Any patients diverted to hospitals with lower rates would create savings over contracting only with higher cost hospitals providing the broadest range of services. In other words, savings are not necessarily proportional to the number of hospitals excluded.

The above clearly underlines a crucial point about the contracting process: the decision about which hospitals get contracts must take into account where patients will go if a particular hospital does not receive a contract. A particular hospital may not have offered GOSHN the degree of savings it was seeking, but if GOSHN thought that former patients from the hospital would otherwise seek care at more expensive hospitals, it might be cost-effective to give the hospital a contract. Some respondents thought the dynamics of the modeling process might have caused GOSHN to be harder on hospitals with mid-range costs than other hospitals. High cost hospitals were needed in the program to guarantee coverage for necessary services and there was no disadvantage to contracting with lower cost hospitals because they divert patients from higher cost hospitals. The only way to meet savings targets may therefore have been to squeeze hard on the hospitals with mid-range costs.

Thus, even aside from the general preference to contract with a relatively large number of hospitals, the dynamics of the modeling process probably caused GOSHN to contract with more hospitals than were strictly necessary to meet service needs. As one former GOSHN negotiator put it: "It just isn't as simple as knocking out a few high cost hospitals and then you have savings."

4.1.3 Section 14083 Considerations

As mentioned in Chapter 2, in addition to target savings, GOSHN was mandated by the terms of Section 14083 in AB 799 to consider certain other factors in awarding contracts. These factors included:

- beneficiary access;
- utilization control;
- ability to render quality services efficiently and economically;
- demonstrated ability to provide or arrange needed specialized services;
- protection against fraud and abuse;
- other factors which would reduce costs, promote access, or enhance the quality of care;
- capacity to provide tertiary services--such as specialized children's services--on a regional basis;
- recognition of the variations in severity of illness and complexity of care; and
- existing labor-management collective bargaining agreements

GOSHN claims it took these factors into consideration in a variety of ways. In the first place, prior to the beginning of the bidding process, a report was prepared by a consultant which set forth standards for determining appropriate access standards. This report, as well as the other constraints, formed a backdrop for evaluating all bids. Additionally, DHS staff worked with GOSHN to develop minimal travel time standards and to assemble data which allowed GOSHN to determine how well those standards had been met.

In addition, GOSHN developed quantitative weightings for each of these factors. After a general configuration model was developed based on the bids received, the 14083 factors were included in the model at various weights to determine if these factors changed the relative attractiveness of the bid. GOSHN staff thought that these factors rarely, if ever, changed the

outcome. In general, they attributed the lack of impact to the high correlation between price and service coverage. It also seems likely that many of these considerations were addressed simply by the fact that so many hospitals received contracts. Given the difficulty in quantifying several of these factors, it is not clear what other argument could prove or disprove GOSHN compliance.

4.1.4 Political Considerations

Much as been made of the apolitical nature of the contracting process. Guy is purported to have told the legislature prior to his appointment "One telephone call and I am gone." One of the former GOSHN negotiators said:

> I know for a fact there was no political tampering. There were a few calls at first, but their requests were pleasantly refused and then it dried up.

No evidence was uncovered in the course of the case study which suggests appreciable direct political intervention.

On the other hand, indirect political considerations influenced the award process at many junctures, most importantly in dealing with county hospitals. GOSHN negotiators indicated that extraordinary efforts were made to award contracts to county hospitals. Indeed, every county hospital in closed HFPAs received a contract. In part this reflects the reality that county facilties in California have historically treated large numbers of Medi-Cal patients and failure to contract with these facilities would have been extremely disruptive. But the result is also indicative of GOSHN's ability to avoid the need for direct political intervention because of its sensitivity to political issues.

Negotiations with San Francisco and Los Angeles Counties illustrate

GOSHN's political sensitivity. San Francisco General Hospital (SFGH) was given a contract in the first round of San Francisco negotiations. Many respondents suggested that SFGH received its contract through political influence, pointing to the high rate as evidence that the contract could only have been awarded by political influence. GOSHN negotiators deny that any special political deal was made for SFGH, but concede that "it went down to the wire" and only a series of last minute phone negotiations allowed SFGH to get a contract. While it is undoubtedly true that many hospitals were involved in last minute negotiations, it is also true that other hospitals were not offered the option of last minute negotiations or the negotiations had different outcomes. Thus, whether or not there was direct political intervention, it is clear that GOSHN reacted in a manner which minimized political problems.

The same observation can be made about the negotiations with Los Angeles County. These negotiations were one of only two in which Guy himself was directly involved. At one point, he even appeared before a session of the Los Angeles County Board of Supervisors. Whether or not there was direct political intervention, the resulting actions again avoided a potentially explosive political confrontation. As one county health official responded:

> When people think of political influence they immediately think of senators getting on the phone. It's not necessarily like that. You don't have to say a lot in situations like this. Some things go without saying.

Perhaps it is the ultimate measure of Guy's sensitivity to political issues that he managed to get through the contracting process with so little overt political influence. Although, the fact that so many hospitals received contracts--and that many of those hospitals which did not receive contracts were not particularly concerned about receiving contracts--surely made it much

easier to complete the process without political interference.

4.2 The Negotiating Process

The theoretical structure for negotiating contracts can be described fairly simply. The actual process, it appears, was not so straightforward.

The general theory was that the hospital would come to Sacramento for two meetings. The first meeting would be an orientation meeting in which the hospital and the negotiator met, walked through the model contract, and addressed immediate questions. The second meeting was more substantial in which the hospital would present its initial offer. The initial offer would be discussed and if necessary the hospital would subsequently submit a best and final offer which would then be used by GOSHN as the basis of a decision, at least on price.

In practice, the procedure often involved multiple sessions to work out contractual language and in many cases, perhaps most, included a series of back and forth telephone negotiations. These negotiations sometimes became quite involved. Some of the complication stemmed from the internal organization of GOSHN. An individual negotiator would settle on terms with a hospital and then take that back to the chief negotiator who would review the proposed contract, particularly in light of the overall negotiation in the HFPA. Often, either because of specific needs within an HFPA or because of a perceived weakness in the contract, the chief negotiator would determine that further reductions in price should be obtained. As one negotiator described it:

> There was always more than one negotiation involved. First there was the individual negotiator and the hospital. Then there was the negotiation with the chief negotiator. It is not clear which was more intense.

The net effect, as will be further discussed in Chapter 5, was not unlike the kind of situation that arises in car dealerships. (i.e., "I'd love to approve this deal, but the manager just won't let me give you that much on the trade-in.")

This two-tiered negotiation process often led to confusion, particularly during the first few rounds of negotiation before procedures had been stabilized. It is worth quoting at length from the brief filed by St. Mary's Hospital as part of its litigation against GOSHN. Whether or not this version of events is literally accurate--the GOSHN legal response argues rather obliquely on the matter--the general scenario is consistent with many hospital respondents' comments about the early negotiations:

> Negotiations between St. Mary's and the state continued during the next month with an Assistant to the Special Negotiator conducting negotiations on behalf of the state. During the course of negotiations, St. Mary's reduced its requested per diem prices from $693 for medical/surgical services and $349 for psychiatric services to $613 for medical/surgical services and $325 for psychiatric services.
>
> On Friday, November 12, 1982, at approximately 3:00 p.m., the negotiator spoke by telephone with James Metcalfe, the Chief Executive Officer of St. Mary's Hospital, concerning the proposed Medi-Cal contract. At the beginning of the conversation, the negotiator stated, "We have accepted your $613 and $325 prices." The negotiator then went on to discuss certain other terms and conditions of the contract apart from the proposed charges. St. Mary's tentatively agreed to all of the changes requested by the negotiator, subject to final discussion with legal counsel. At the conclusion of the telephone conversation, the negotiator asked if she could tell the Special Negotiator that "we have a contract." Mr. Metcalfe told her that she could, subject to approval by St. Mary's legal counsel.
>
> Later the same day, St. Mary's Chief Financial Officer contacted the negotiator on behalf of St. Mary's and confirmed that the Special Negotiator's requests regarding the contract terms were acceptable to St. Mary's, with the exception of a few minor details to which the negotiator readily agreed. The issue of price was not discussed in this conversation.

> The next day, Saturday, November 13, 1982, the negotiator again called St. Mary's Hospital. When the Chief Financial Officer returned her call, she asked if St. Mary's could reduce its $613 per day proposed charge for medical/surgical services to $593 per day. He responded that he was not authorized to make such a decision--that any reduction would have to be approved by Mr. Metcalfe, the Chief Executive Officer.
>
> On Monday, November 15, 1982, Laurence W. Kessenick, Esq., St. Mary's attorney, spoke with Special Negotiator William Guy. Mr. Kessenick emphasized St. Mary's belief that a price already had been agreed to on November 12, and attempted to determine if, in fact, the requested $20 reduction would be required. Mr. Guy asked if the $20 difference were the only problem--if all the other terms had been agreed upon. When Mr. Kessenick replied that the $20 figure was the only issue, Mr. Guy stated that $20 did not sound like a big difference and that he felt the matter could be worked out.
>
> After Mr. Kessenick's conversation with William Guy, St. Mary's Hospital heard nothing else from the Special Negotiator's office until November 17, 1982, when St. Mary's was informed that it would not receive a contract to provide inpatient hospital services to Medi-Cal beneficiaries.

After the first round, however, the negotiation process became more routine. There were fewer complaints of situations like the above in HFPAs which were negotiated later. There were, however, other factors which made contracting unlike other procedures used by Medicaid programs.

One of the most important of these is that the negotiation process can lead to contractual terms which differ greatly from one hospital to the next. The general decision rules outlined in Section 4.1 led to situations where some hospitals are identified as critical because they provided needed services or because of their high historic Medi-Cal load. Barring other access problems, the primary reason for contracting with the less critical hospitals was because those hospitals might have lower rates than the "critical" hospitals and any patients diverted into the lower cost hopitals resulted in savings. This distinction between critical hospitals and non-

critical hospitals led to differences in contractual terms. If the final submission of a non-critical hospital did not come reasonably close to the target rate for that hospital established by GOSHN (related to the hospital's historic Medi-Cal rate), that hospital was not likely to receive a contract. In fact, it might not even hear from GOSHN again until it was notified it had not received a contract.

However, according to GOSHN respondents, if any hospital made a final bid that was "responsive" GOSHN would continue to negotiate with that hospital. In general, GOSHN negotiators felt that all hospitals were given fairly clear guidelines as to what kind of bid was necessary to receive a contract. Respondents indicated that hospitals which made significant movement in their final bid from their historical Medi-Cal rate were likely to be given subsequent chances to meet GOSHN expectations. (Of course, "subsequent chances" can also be interpreted as a euphemism for being subjected to additional pressures to lower the final bid.)

Hospitals deemed critical by GOSHN could play a much tougher hand if they were willing to take the risk. Many of the hospitals with which GOSHN was most in need of contracting realized their relative bargaining strength. Thus, some hospitals were able to bargain for terms extremely different from those available to other hospitals. For instance, in one HFPA, we found two cases where a hospital had been told that under no circumstances could it have certain terms in its contract, but where a nearby competitor had such terms in its contract. A former GOSHN negotiator stated it most simply: "When you need a hospital, you might be willing to agree to terms which you otherwise would not have found palatable."

4.3 The Lessons from San Francisco

San Francisco was the first HFPA closed. Three of the largest Medi-Cal hospitals in the city were not awarded contracts: St. Mary's, Mt. Zion and the University of California at San Francisco (UCSF). These three hospitals provided a significant number of special services and among them had historically provided 40% of the Medi-Cal days in San Francisco. St. Mary's immediately went to court, sought, and received a restraining order which prevented the state from excluding them from the Medi-Cal program. Mt. Zion joined the litigation, but did not seek a restraining order and accordingly could be reimbursed only for emergency cases as of February 1, 1983, when the contracts went into effect in San Francisco. UCSF did not enter into the litigation and was therefore also excluded from the Medi-Cal program except for emergency cases.

After several months, however, the litigation was settled out of court and the San Francisco HFPA was reopened for bidding. After the second round of bidding in San Francisco, every acute care hospital in the city had a Medi-Cal contract.

4.3.1 The Message to Other Hospitals

When the results of the first negotiating process in the San Francisco HFPA were announced the message to hospitals in other HFPAs was clear and electrifying: GOSHN was serious. The common anecdote, generally confirmed by GOSHN respondents, was that within twenty-four hours GOSHN received calls from all the major hospitals in Los Angeles substantially lowering their bids.

It is not clear whether San Francisco was deliberately used to send a message or whether San Francisco was used to test whether it was possible to eliminate major Medi-Cal providers, an approach which ultimately proved

unsustainable. Given Guy's stated interest in contracting with the largest possible number of hospitals, one is tempted to suspect the former, the protestations of former GOSHN staff notwithstanding. The only way in which GOSHN could both contract with a large number of hospitals and meet its savings target would be if virtually all hospitals were willing to contract for rates well below their historic Medi-Cal rates. Hospitals would accept such rates only if they believed that meeting GOSHN's rate demands was the only way to maintain their current Medi-Cal load. The most efficacious way to deliver this message was to actually decline to contract with some important Medi-Cal hospitals.

If the three San Francisco hospitals had offered lower rates, the message might have been sent elsewhere. Or, perhaps, if hospitals all over the state had submitted rates low enough for GOSHN to meet its savings targets, the message would not have been needed. But the fact is that by declining contracts to three of the largest hospitals in San Francisco, all with large Medi-Cal populations, GOSHN clearly established that hospitals which did not meet its rate demands put their hospital's participation in the Medi-Cal program in jeopardy. And, as many hospital respondents acknowledged, the serious threat of losing a large portion of revenues is sobering.

4.3.2 The Court Battle

According to CMAC, the depositions and briefs filed as part of the St. Mary's litigation are confidential as part of the consent decree settling the matter. Consequently, it is not possible to know exactly how the respective cases unfolded. It is clear from the initial complaints, which are publicly available, that St. Mary's arguments fell into two main categories--substantive and procedural.

Substantively, St. Mary's alleged that the state failed to live up to the terms of the Federal waiver in that it failed to guarantee sufficient access for special needs populations. St. Mary's argued in particular that GOSHN had failed to adequately contract for services to Southeastern Asian refugees and adolescent and pediatric psychiatric patients. St. Mary's argued that it had unique capabilities to provide these services and that other providers could not adequately meet those needs.

Procedurally, St. Mary's argued that the negotiating process had not been fair since it had been led to believe by GOSHN that its rate offer had been accepted, only to discover after the process was over that the offer was not satisfactory.[5] A second procedural argument was that GOSHN, even after declaring the HFPA closed, was still negotiating with a hospital to provide adolescent psychiatric care.

There is no way to know who would have won had the litigation not been settled out of court. Both St. Mary's and former GOSHN staff members contend their side would have won had the case been tried. However, and this no doubt explains why the case was settled, both sides acknowledged that the rebidding was a satisfactory alternative to prolonging the litigation. St. Mary's (and Mt. Zion) were allowed to continue as Medi-Cal providers; GOSHN, on the other hand, had already signed contracts with hospitals in the rest of the state at favorable terms and was confident that it could rebid San Francisco and still achieve target savings. It is impossible to determine from data whether GOSHN actually achieved its original savings in the rebidding, although the ultimate rates for both St. Mary's and Mt. Zion were

[5]Portions of their complaint covering this aspect of their argument were cited in Section 4.2.

It is quite interesting to note that the St. Mary's case was the only litigation of the entire contracting process and that it was primarily oriented at the specific failure to win a contract rather than the contracting process itself. Previous sections have argued that the general strategy of the contracting process was to persuade hospitals to offer drastically lower Medi-Cal rates by threatening the loss of Medi-Cal revenues. From a purely economic standpoint, the net effect was not appreciably different from an across the board rate rollback since there was no serious attempt to reroute recipients to lower cost hospitals. It seems likely, however, that if such a rollback were directly attempted, it would have touched off major litigation. In 1981, for instance, an attempt by the California legislature to limit the rate of growth in hospital rates to six per cent was disallowed by the courts; yet it would appear contracting resulted in rate decreases in the order of sixteen percent.

When all is said and done, one of the notable achievements of contracting is to effect a rate rollback of that order of magnitude with so little litigation. Although it is impossible to ascertain all the reasons why contracting failed to endgender a universal legal challenge, a reasonable speculation is that the entire nature of the contracting process makes it much less vulnerable to litigation than action by a state Medicaid agency which affects all providers. GOSHN could defend any challenge in court by arguing, first, that all contracts took into consideration the individual characteristics of each provider; and, second, that if the hospital found the terms unsatisfactory, it did not have to enter into the contract. Hospitals could have entered into a class action arguing that GOSHN had such unfair leverage as to render the whole notion of contracting coercive. However, that argument is much more difficult to prove than the argument that a Medicaid

agency harmed hospitals across the board by arbitrarily reducing rates. Moreover, the one-on-one nature of contracting results in a situation where some hospitals are in fact satisfied with the contracting rates and willing to assume other hospitals' case load. Contracting creates a very different dynamic in the provider community than an across the board rate reduction. In the latter case, no provider has anything to lose by getting the rollback cancelled.

Another explanation for the lack of legal action is that the CHA felt under extreme pressure to avoid involvement in the process for fear of violating anti-trust provisions. Thus, the natural rallying point for possible litigation was neutralized.

4.3.3 Viability of the Original San Francisco Configuration

One of the most interesting questions about the San Francisco experience is whether or not the original configuration would have adequately served to Medi-Cal recipients. The question is of great importance both for the future of the California contracting program and for other states considering contracting. If the answer is that the removal of three major teaching hospitals from the program made it impossible to deliver adequate care to Medi-Cal recipients in San Francisco, the implied threats of contracting may eventually lose their potency. On the other hand, if it is possible to achieve major relocations of Medi-Cal patients, the leverage of the contracting agency is greatly stengthened.

It is not possible to unequivocally determine what impact the configuration originally announced by GOSHN would have had on Medi-Cal health care. In the first place, St. Mary's was successful in obtaining a temporary restraining order and it was able to continue providing care to Medi-Cal

recipients. Second, both Mt. Zion and UCSF claim they continued to care for some Medi-Cal recipients under the assumption that the interruption of Medi-Cal business was only temporary.

Nevertheless, community sentiment on the issue was strong that it would have been possible to deliver adequate care to Medi-Cal recipients under the initial configuration. Some respondents cautioned that there would have been some problems with a few specific services, neonatal intensive care being the most frequently mentioned. And the originally excluded hospitals contended that there would have been general shortages of specialized services. But the prevailing attitude was that with state approval for special needs (i.e., rare surgeries performed only at UCSF or occasional overflows for other high intensity services) there was sufficient inpatient capacity in the hospitals originally receiving contracts to serve the Medi-Cal population.

Again, there is no hard evidence for this proposition; only the speculation of a sample of observers. Moreover, issues other than the availability of inpatient services might have impacted the viability of the original configuration--for instance, the impact of contracting on outpatient services. Nevertheless, the anecdotal evidence on this partial experiment suggests that from a programmatic standpoint it may be possible to exclude major hospitals and still provide adequate care to Medi-Cal recipients.

In addition to the programmatic issue, however, there is the question of whether the original configuration was politically viable. There was no consensus among respondents about the political viability of maintaining the original San Francisco configuration. While there was no evidence of direct political intervention on the issue, respondents contended several key actors lobbied GOSHN and elsewhere to reopen the area. Respondents even

asserted that some of the hospitals which did receive contracts were lobbying GOSHN to reopen the area for fear of having to treat too many high intensity Medi-Cal cases. Most respondents suggested that GOSHN's eventual position was much more politically palatable than the original configuration, but few were willing to speculate on what would have been the political ramifications of failing to rebid the area. Most respondents felt, however, that excluding San Francisco General Hospital would have caused serious political problems and that political sensitivity was shown in that aspect of the San Francisco situation.

4.4 Negotiation in the Remainder of the State

Negotiations in the remainder of the HFPAs created much less public controversy than in San Francisco. After San Francisco, hospitals were more willing to come to terms with GOSHN. Moreover, there were learning effects both for GOSHN and the hospitals. GOSHN avoided situations as awkward as the St. Mary's negotiation, in part by rarely declining to grant contracts to hospitals which negotiated seriously. Hospitals, on the other hand, knew GOSHN was serious and were more likely to make competitive offers. However, negotiations with the Los Angeles County Hospital System and in the HFPAs in which no contracts were awarded provide additional insight into the negotiation process.

4.4.1 The Los Angeles County Hospital System

It is difficult to overestimate the importance of the Los Angeles County Hospital System (LAC) for the Medi-Cal hospital budget. In 1981, LAC hospitals received $78 million from Medi-Cal. This was 11.3% of the entire Medi-Cal inpatient hospital budget (excluding Medicare cross-overs). While

about 45% of this amount was for care to the MIA population, and not subject to contracting, the dollars involved were still substantial.

Negotiations with the LAC hospitals started early and went long and hard. One of the HFPAs with a January 1, 1983 implementation date (later postponed to February 1) was the Long Beach area, south of Los Angeles. Harbor/UCLA Medical Center, the second largest Medi-Cal hospital in the state and a major LAC hospital, is located in this HFPA. LAC officials, however, had decided to negotiate all the county hospitals under a single contract with a single rate. GOSHN attempted to negotiate with Harbor directly and, when LAC officials proved reluctant, threatened to close the HFPA with Harbor excluded. The Los Angeles Board of Supervisors became quite concerned--"panicked" was the term used by one respondent--and the negotiations with LAC reached their first crisis point. It was during this period that Guy addressed a closed meeting of the Los Angeles County supervisors. According to observers, he was extremely personable and created a favorable impression with the supervisors. That particular crisis was settled by allowing Harbor to continue providing Medi-Cal services and be reimbursed on an interim basis.

Negotiations, which had started in October, continued on into January. At one point the question of what LAC's actual costs were became so snarled that consideration was given to employing an outside fact-finder. Apparently, however, both sides decided against that course of action because the risks to either party were too great. Eventually a compromise was reached at $640 a day for care in any of the LAC hospitals, a figure which a GOSHN negotiator characterized "too much for some of the hospitals, but on balance probably fair." LAC officials have indicated that they think their actual costs were probably closer to $664 per day, but, that on balance, they were happy with the settlement. They felt that was as much as they would have

happy with the settlement. They felt that was as much as they would have gotten on a cost based settlement and this avoided the problem of long and involved cost settlements.

Discussion of the contracting process for LAC hospitals raises questions about the viability of contracting as a method for dealing with public institutions which have such a disproportionate share of Medi-Cal business. State leverage is obviously reduced in such situations. While both LAC officials and former GOSHN negotiators conceded that contracting might have proceeded without some individual hospitals in the LA system, neither thought contracting would have been feasible without some participation from the county.[6] Likewise, both agreed that state revenues were so critical to the LAC hospitals that a failure of the state to resolve the situation was unthinkable. However, there was still room for bargaining. As one respondent said, "The state deals with Los Angeles County on a lot of issues besides health care. The state is not without other strings."

4.4.2 HFPAs Without Closure

As of May 1984, contracting was in place in only 67 of California's 138 HFPAs.[7] The majority of the HFPAs which did not have contracting were rural areas with a very small percentage of the Medi-Cal caseload and, often, with only one hospital. It was GOSHN's, and CMAC's, opinion that contracting in these HFPAs was not a high priority because of the negligible savings.

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[6]Curiously, LAC officials and GOSHN negotiators did not seem to agree on which individual hospitals the state could have forgone contracting with.

[7]At the beginning of contracting there were only 137 HFPAs, but a new one was added. Therefore, there are occasional inconsistencies in certain HFPA statistics.

Closed HFPAs have historically contributed about 87% of the state's Medi-Cal inpatient utilization.

As of May 1984, there were, however, five HFPAs which collectively accounted for about 5% of total historic Medi-Cal utilization in which GOSHN wanted to contract but was unable to reach closure. That is, GOSHN did not award contracts in those areas because the resulting configurations were not viable, either from a fiscal standpoint or from a programmatic standpoint. For instance, in one HFPA all the hospitals were holding their line on prices. In several other HPFA, some hospitals submitted acceptable bids but did not have the entire range of necessary services or were unable to absorb the additional Medi-Cal volume which would have been diverted to them given the unacceptablity of bids from other hospitals in the HFPAs.[8]

In HFPAs where contracting is not implemented, reimbursement continues on a per-discharge, cost-related reimbursement system. However, the reimbursement per discharge is capped at the 60th percentile of reimbursement for hospitals within each of the 12 peer groups established by the California Health Facilities Commission.[9] This peer grouping approach was proposed prior to contracting but was not implemented until after contracting went into effect. (Its implementation had been tied up in the courts for some time.) The effects of the peer grouping system were quite draconian for hospitals in the upper percentiles. Some hospital respondents claimed they fared better under contracting than they would have under the peer group system.

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[8]Two of these were closed during the summer of 1984, but the odds of closing the other three in the future did not seem particularly high.

[9]There are actually 18 peer groups, but rate limitations govern only 12 of the peer groups since the other six groups have very few hospitals. About one-third of the noncontracting hospitals are rural hospitals and are exempted from the peer grouping system.

Presumably, however, the peer grouping system is not perceived as being so strict in those HFPAs which have not closed or hospitals would have been more accomodating to the negotiating process.

CHAPTER 5

BIDDING PROCESS: HOSPITAL PERSPECTIVE

This chapter considers the bidding process from the hospital perspective, including hospital motiviation in bidding, hospital preparation for bidding, and the negotiation process itself.

5.1 Hospital Motivation

In California, as elsewhere, hospitals had for several years complained bitterly about the Medi-Cal program. For example, hospital administrators complained that Medi-Cal reimbursement rates "rarely" covered hospital costs, that the "bureaucratic delays" in processing claims caused cash-flow problems, and, in sum, that the Medi-Cal program "just wasn't worth the trouble." While in theory hospitals could have dropped out of the Medi-Cal program, as a practical matter this would have been difficult, particularly from a public relations standpoint. But selective contracting was an opportunity to start over. A hospital which did not want to participate in the Medi-Cal program could blame its exit on the state. It is clear the state was concerned about this possibility. Guy threatened to seriously question the Hill Burton compliance of any hospital which did not bargain in good faith. Likewise, Guy and others raised the possibility that failure to make at least a good faith effort to obtain a contract could have a negative impact on future Certificate of Need applications. Nevertheless, according to several of the GOSHN respondents, as the first bids were requested, it was not at all clear how many hospitals would respond.

As it turned out, most hospitals entered the bidding process. During the first two phases (all HFPAs closed on or before May 1, 1983), only 11 percent of the eligible hospitals did not submit bids. According to our respondents, however, some of the bidding hospitals were not bidding seriously but were merely going through the motions for public relations or to avoid later Certificate of Need hassles. General evidence for the questionable sincerity in some contractual efforts can be seen in the fact that as a group non-contracting hospitals were restricting the amount of Medi-Cal services they provided prior to the onset of contracting. DHS data shows that between July 1980 and August 1982 non-MIA Medi-Cal users declined by 3 percent in hospitals which later received contracts, but declined by 25 percent in hospitals which became non-contracting hospitals.[1] Thus, even before the onset of contracting, these hospitals were reducing the amount of relative Medi-Cal coverage being provided.

Many hospitals bid with a certain ambivalence. As one hospital administrator summed it up:

> After long consideration we concluded it was less disadvantageous to have a contract than to not have one.

Another administrator put it more colorfully:

> Getting a contract was like having your worst enemy drive over a cliff...in your new car.

To be sure, some of the expressed sentiment was the same poor-mouthing of Medi-Cal which hospitals have been doing for years. But even hospitals which candidly admitted that they were doing well under the contracting program

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[1] A "user" is a person who was in a hospital during a particular month. This is a reasonable surrogate for hospital admissions since, over any period of time, the number of users in a month is a function of the number of admissions. For any individual month, however, the number of users may be greater than the number of admissions because a person whose hospitalization overlaps two months will be recorded as a "user" in both months.

expressed concern about the inequities between Medi-Cal and other payers, about the difficulties of dealing with Medi-Cal, about the one-sideness of the negotiation process, and about their desire to find a more "equitable" approach to reimbursement. This fundamental ambivalence about the Medi-Cal program may be important in trying to gain acceptance of future reforms or it may have long-run implications for CMAC's ability to hold the line on rates.

5.1.1 Protecting Current Medi-Cal Share

The most common theme expressed by hospitals in explaining why they ultimately bid was their desire to protect their current Medi-Cal business. Very few showed interest in expanding their Medi-Cal share.

The most obvious reason for protecting existing Medi-Cal patients was to protect the share of income associated with Medi-Cal. Few hospitals could afford to lose 8, 10, 12 or more percent of their revenue at one time. The economics compelled hospitals to consider reductions in Medi-Cal revenue in order to avoid losing it all.

Less directly, but equally economic in orientation, was the hospitals' need to "protect" admitting physicians. Hospitals were concerned that if they did not get a contract, physicians with significant Medi-Cal practices would take not only their Medi-Cal practices to contract hospitals, but also their Medicare and private-pay as well. This motivation was rarely, if ever, mentioned as a primary concern, but virtually every contracting hospital conceded its importance.

In general, physicians were not particularly enthusiastic about contracting, but did not specifically stand in the way either. Most hospitals reported that there was a segment of their physicians who would have preferred that the hospital not get a contract, but they realized that it was in the hospital's better interests to have a contract. As one Chief of Staff put it:

> There were a lot of guys who really wanted to go without a contract, but they went along because they knew there were guys in OB and some other services that had big Medi-Cal caseloads and needed protection.

One hospital administrator suggested that one reason medical staffs seemed so unenthusiastic about Medi-Cal contracting is that staff "leadership" in many hospitals is predominantly older and more established physicians with little or no Medi-Cal caseload. Medi-Cal caseloads are concentrated in the younger physicians who are less vocal in hospital affairs.

In any event, hospital administrators pursued contracting, and were not particularly guided by physician sentiment on the issue. As one administrator said, "Whatever their feelings, physicians do not make the final decisions on such matters."

Although economics were apparently the primary issue, hospitals also had other stakes in Medi-Cal which they were trying to protect. Many articulated that they were trying to protect their historic role in caring for all segments of the community--particularly those individuals or communities which had long-standing relationships with the hospital. One hospital administrator, for instance, described a long-standing relationship with a Southeast Asian community: "We have all the medical records on three generations." To be sure, most hospitals seemed to have a limit to that interest. As the CFO of a Catholic hospital put it, "We have a real mission to serve the poor and we accept that mission. But going out of business won't help us or the poor."

Another important factor for some hospitals was the protection of teaching functions. Hospitals with teaching programs suggested that protecting their teaching functions compelled them to bid, particularly those hospitals with programs in high Medi-Cal volume services such as obstetrics, gynecology, or pediatrics. Hospitals were concerned not only about providing interns and residents the necessary inpatient experience, but they were also

concerned that not having a contract might limit outpatient educational opportunities. Many hospitals expressed the opinion that if clinic staff could not admit and follow up on a patient, the patient should not be seen at that clinic.

Finally, hospitals felt pressured to protect their access to debt financing. Two hospitals, both of which were approaching construction projects coincident to the beginning of contracting, were very concerned about protecting their bond rating. One of these reported that the rating agencies were quite explicit that the hospital's bonds would not be rated unless it had a Medi-Cal contract.

5.1.2 Expanding Market Shares

Very few hospitals showed interest in expanding their Medi-Cal share. Hospitals were more concerned about controlling the number of new Medi-Cal patients. Hospitals in our sample, for instance, had contracts which were contingent on the county hospital receiving a contract; which were contingent on a minimum number of other hospitals in the HFPA receiving contracts; or which attempted to control Medi-Cal utilization in other ways. One of the non-contracting hospitals in our sample was so serious about the point that it was denied a contract when it insisted that its contract contain a specific limit on the number of additional Medi-Cal admissions in various services and GOSHN would not accept such a limitation. Thus, despite California's well-documented low occupancy rate, we found little general interest in raising that rate with Medi-Cal patients.

Administrators from only one hospital in our sample stated that they entered the bidding process with the clear objective of gaining additional Medi-Cal patients. Administrators from a second inferred that goal, but did

not express it as a clear objective. Additionally, two hospital opinion leaders indicated that they had entered into contracting to seek new Medi-Cal volume. Three of these four respondents claimed adamantly that they had been told by GOSHN negotiators that they would get a volume increase because only a limited number of contracts would be signed.

These hospitals assumed that their fixed costs were being covered by existing payers and that additional Medi-Cal recipients would incur only marginal costs. Three factors are worth noting here. First, the number of hospitals following this logic was quite small; as stated above, hospitals seemed much more interested in protecting current Medi-Cal share than in expanding it. Second, hospitals looking for larger Medi-Cal shares may have been misled by GOSHN negotiators or they may have simply gotten carried away by their own hopes. Despite Guy's statements about wanting to contract with as many hospitals as possible, there is quite a bit of evidence that GOSHN negotiators were not always clear about how many contracts they planned to award, particularly in the first wave. Third, regardless of the source of their expectations, none of the four experienced any appreciable increase in Medi-Cal recipients. In part this was due to the large number of hospitals with whom contracts were signed, but it was also due to the transfer of the MIAs and the change in the definition of medical necessity.

Interestingly enough, one of the two hospitals which terminated its contract before May 1, 1984, left the program because a "promised" increase in Medi-Cal recipients failed to materialize. The other hospital dropped out because its increase in Medi-Cal recipients was "too large" relative to its per diem and its desire to avoid being seen as a "Medi-Cal mill."

5.2 Hospital Preparation for Bidding

There were differences in the degree of preparation undertaken by hospitals. Probably the most extreme example in our sample was a hospital which set up a committee of the CEO, CFO, two representatives from the medical staff and two representatives from the hospital Board of Directors. Six assistant administrators worked directly with the committee in preparing the hospital's bid. From the time the legislation was passed, they worked to develop baseline data on costs, utilization and so forth. The hospital estimated its expenses for external consultants at $70,000 and internal expenses at double that amount. As a result, the hospital changed the entire accounting approach to a costing system which estimated fixed and variable costs for each payer by medical specialty. While the system was only partially completed at the time of negotiations, the hospital felt it provided a solid base for considering the implications of different bids at varying volume levels.

Most hospitals in our sample were much less extreme in their preparations, although all but a few undertook some quantitative efforts prior to the negotiations. At a minimum, these efforts consisted of reviewing baseline data to make sure the historic Medi-Cal costs, utilization and revenues were understood as well as possible and to determine historic fixed versus variable costs. Most hospitals believed they had a solid handle on fixed versus variable costs and on average costs, but many were uncertain about whether that distinction gave them enough information to consider marginal costs.[2]

Some hospitals devoted attention to possible bids by potential "competitors." However, according to respondents, once the actual bidding

[2]It was not entirely clear to hospitals that simply dividing costs into fixed and variable costs really provided enough information to predict with any accuracy how much the loss or gain of a given number of patients would change costs.

process got underway, it became apparent that in most cases hospitals were not bidding against possible competitors but were bidding against "targets" determined by GOSHN. As discussed earlier, these "targets" were sometimes a hospital's previous costs and sometimes a "community average." GOSHN negotiators were unable, or unwilling, to specify if hospitals were pushed toward one or the other of these targets; responses from hospitals suggested that both approaches were used.

Many hospitals used external consultants to some degree in the process of preparing their bids. Typically, hospitals used their usual financial consultant or accountant. At least one hospital reported using a type of service bureau that had prepared a small software package called "Czar-cast," consisting of a series of "what-if" statements a hospital could use to analyze its historic experience. Several hospitals expressed uncertainty as to the value of their external consultants. Former GOSHN negotiators expressed the opinion that many of the accounting advisors did not seem particularly useful because they were still thinking more about average costs than considering the marginal cost considerations of potential volume changes.

A few hospitals clearly had not prepared well. In our sample, these were primarily small proprietary hospitals. One hospital administrator simply stated that their records were so bad that they had no baseline data. Another hospital reported that it did not receive a contract because it did not have the data to back up its arguments to GOSHN. Another hospital assumed that because of its location and religious affiliation it would receive a contract, an assumption which turned out to be incorrect. How much difference better preparation would have made in any of these cases is open to question, but our interviews suggest that those hospitals who fared worst were in some respects less prepared.

In retrospect, the main failure of hospital preparation was not correctly anticipating the volume implications of the transfer of MIAs and the change in the definition of medical necessity. Hospitals knew about the MIA change, but for the most part their accounting systems had recorded only that a patient was Medi-Cal and made no distinction by type of Medi-Cal eligibility. Consequently, hospitals were unable to make an accurate estimate of the number of their Medi-Cal recipients who were MIA eligible as opposed to other eligibility types. As far as the impact of the change in the medical necessity definition, it is fair to say that everyone, including the state, was somewhat surprised at the magnitude of the utilization decrease. Hence, it is not surprising that hospitals failed to account for it correctly.

A second area of preparation had to do with the contractual language. Most hospitals used lawyers, in some cases their usual corporation counsel, in other cases special counsel. The latter was particularly common in the later stages of the contracting process, particularly in Southern California, where one law firm represented quite a few hospitals. Most respondents had a rather ambivalent attitude toward their lawyers. On the one hand, they were reluctant to say that the lawyers were a waste of money; on the other hand, they were not sure the lawyers negotiated terms that the hospitals could not have gotten on their own. Former GOSHN negotiators, however, suggested that those firms which retained knowledgeable lawyers did somewhat better on the contractual language than those that did not. However, they credited much of this result to learning effects: lawyers who negotiated more than one contract were the only people who were able to learn much about the

process because of GOSHN's largely successful efforts to keep all aspects of the negotiation secret. Thus, the lawyers could learn from both mistakes and successes.[3]

As with the price aspect of the negotiation, there was some evidence in our sample that hospitals which prepared better did better. Two hospitals, again relatively small proprietaries, were either not sufficiently aware of the need for detailed service exclusions (Appendix A) or were totally unaware of the possibility of negotiating complete exclusions for services which the hospital did not provide.

In any event, it is unclear that additional preparation concerning contractual language would have made much difference. The degree of compromise which GOSHN was willing to make seemed much more related to how much they wanted the hospital than to how much the hospital wanted from GOSHN.

5.3 Negotiation Process

For some of the same reasons that hospitals were ambivalent about whether or not to pursue contracts, they were ambivalent about the negotiation process itself. Most hospitals conceded that there was some give and take in the negotiating process. And most hospitals felt that their negotiator was professional.[4] Nevertheless, the vast majority of hospital respondents resented what they perceived as the inequity in relative bargaining positions. Most felt the state was able to set the ground rules in such a way that the

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[3]CMAC has since adopted a rule which prohibits a lawyer (or anyone else) from representing more than one competing hospital in contract negotiations.

[4]The typical comment was, "Our negotiator was very professional, but we understand not all of them were." Of all the hospitals in our sample and the hospital opinion leaders to whom we spoke, only three had negative comments about their negotiator. More than half went out of their way to offer positive comments about their negotiator.

most basic issues were determined before the process began. What give and take there was centered on the relatively narrower issues of how much the hospital could protect itself through Appendix A service exclusions, patient capacity limits or the like. Typical comments were:

> We were on the phone until the last minute, but I am pretty happy with the contract, all things considered. I think we did better than most hospitals. But I still don't like it. I don't like negotiating when you are at a disadvantage. I intend to make this hospital lean and mean and price competitive to the nth degree until we can go to negotiate without needing Medi-Cal.

or

> I think the process was reasonably fair and there was real appreciation of our problems, but that when all was said and done the hospital still wound up with a contract that is unfair and one-sided.

It is probably inevitable that hospitals felt that way given that for most of them their basic motivation was to protect their existing business and for GOSHN the basic motivation was to obtain maximum price reductions. About half the hospitals in our sample reported receiving phone calls from GOSHN down to the last minute looking for additional reductions, sometimes after the hospital thought agreements had been reached.

Many hospitals made additional rate concessions at the last moment. However, failure to make last-minute concessions did not play a role in the failure of any of the non-contracting hospitals in our sample to receive contracts. These hospitals were non-contracting because of fairly fundamental differences with GOSHN. Conversely, several hospitals in our sample reported that they received contracts despite refusing to make last-minute concessions. Although it is impossible to say no contract awards pivoted on last-minute adjustments, it appears that small concessions after basic agreements had been reached did not make much difference in the awarding of contracts.

One aspect of hospital disenchantment with the contracting process was GOSHN's unwillingness to consider alternatives to a per diem rate. Many hospitals had hoped that in return for rate concessions they would be able to get changes in the unit of payment. They felt a per-discharge rate would help them deal with two of their problems with Medi-Cal--the utilization review process and the lack of congruent incentives for physicians. About half the hospital respondents indicated that their initial proposal included some options for per discharge rates, but, as one respondent summarized it, "GOSHN was not prepared to deal with anything but per diems." Only two hospitals in the state received contracts on any basis other than a per diem. Given the level of interest in different payment units, GOSHN's insistence on per diems contributed greatly to hospital frustration with the process. One respondent lamented:

> I think we lost a good chance to wrestle with some of the basic issues, particularly complexity... Now I get a sense that the state is unwilling to spend any energy on contracting because their energy is going into capitation.

Hospitals were also distressed by the lack of consistency in contractual terms allowed by GOSHN. Hospitals, for instance, were frustrated that they were told it was not possible to have separate rates for different services and later found that other hospitals had them; or that it was not possible for chains of hospitals to negotiate under a single contract and later found that the Los Angeles County hospitals were allowed to do so.

It is hard to determine the degree to which differences in contractual terms resulted from differences in negotiating skills or from differences in how much GOSHN felt particular hospitals were critical. It is important to see differences resulting from GOSHN's determination of its need for a hospital in light of the fact that many hospitals were simply trying to

protect their existing Medi-Cal. GOSHN's only interest was in price and access; if a particular hospital were not needed for access purposes, it had almost no leverage with the state. Such a hospital's only recourse was to accept rates essentially dictated by the state or to give up its Medi-Cal census entirely.

A final source of frustration for hospitals resulted from the premise in the model contract that a contracting hospital would accept full responsibility for all services needed by presenting recipients, including services that the hospital did not provide. The concept proved nonviable and most hospitals were able to negotiate exclusions for the services which they did not provide. However, the contract was structured in such a way that services were included in the contract unless explicitly excluded in Appendix A. Some hospitals, particularly in the earlier phases, were stampeded into accepting responsibility for all cases and have had to pay for services provided at other hospitals--with lengthy squabbles over whether the referring hospital must pay at its per diem or at the per diem of the receiving hospital.

A much more common problem is confusion as to whether or not the hospital was responsible for particular services. In many cases the confusion was simply a result of the fact that DHS was forced to translate an imprecise verbal agreement between GOSHN and the hospital into the very precise language necessary for processing claims. This confusion has led to much renegotiation of contracts as hospitals try to sharpen the clarity of excluded services. The ambiguity has also led to some hospitals experiencing losses on services which they failed to clearly exclude. As one administrator said:

> We ended up with gray areas in our definition of the exclusions, which have led to transfer problems and had some adverse cost implications. Our hospital does provide pediatric care and so we did not specifically ex-

clude pediatric services; however, the hospital does not provide intensive pediatric care and now we are stuck paying for those patients elsewhere until we can get the contract renegotiated.

CHAPTER 6

CONTRACTING RESULTS

This chapter discusses the results of the first round of contract negotiations. The first section describes the results in terms of which hospitals were awarded contracts compared to hospitals that did not receive contracts. Hospital characteristics aggregated from CMAC and the California Health Facilities Commission are examined to determine whether there are significant differences between contract and non-contract hospitals.[1] The next section discusses the results of the contract negotiations in terms of the negotiated rates. Contract rates are compared to the per diems paid prior to contracting. In addition, hospital claims dating back to July 1980 are analyzed to estimate Medi-Cal per diems that would have been paid in the absence of contracting. Finally, the last section reviews the state's methodology for estimating the aggregate savings from contracting.

6.1 Hospital Characteristics

During the first round of negotiations, a total of 335 hospitals were eligible to receive contracts in HFPAs open for negotiation.[2] As indicated in the previous chapters, 245, almost three quarters, of these

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[1]Ownership status and principal type of service was aggregated from the Hospital Service Profiles in Closed Health Facility Planning Areas, Appendix C, Report to the Legislature on the Operations of CMAC, January 1984. Peer group, licensed beds and occupancy rates, and payer revenue percentages were obtained from CHFC individual hospital data reports for fiscal year 1981-1982.

[2]Certain specialty, children's and federal hospitals were exempt from contracting. The group of hospitals used in this analysis includes those hopsitals that are not exempt from contracting and are located in closed HFPA's. The number of contracting or non-contracting hospitals may differ slightly from the numbers reported by GOSHN or CMAC depending on whether hospitals owned by one entity submitted joint or separate claims to DHS.

hospitals eventually negotiated a contract with the state. The remaining ninety hospitals became 'non-contract' hospitals providing Medi-Cal services only in emergency situations. While we did not have information on the number of non-contract hospitals actually seeking contracts, DHS estimated that about seventy percent of the non-contract hospitals continued in the negotiation process long enough to submit a formal written proposal. The other thirty percent eliminated themselves before the written proposal was due, by not responding to the letter of invitation or dropping out of the process after the introductory meeting.[3]

How do contract hospitals differ from non-contract hospitals? Several factors, including ownership, peer group, payer share, service type, occupancy rate, and bed size, were examined to identify those characteristics which distinguish contract hospitals from non-contract hospitals. Only two characteristics were found to differentiate the two types of hospitals -- hospital ownership and the percentage of revenues paid by each payer.

Ownership status of contract hospitals is significantly different from non-contract hospitals, as shown in Exhibit 6.1. Whereas all county and UC hospitals received contracts, only about 60 percent of proprietary facilities received contracts.

As mentioned in previous chapters, county and UC hospitals provided a disproportionately large share of Medi-Cal services. The magnitude of these hospitals' Medi-Cal business is demonstrated in Exhibit 6.2. Medi-Cal revenues in the fiscal year prior to contracting accounted for almost fifty percent of all revenues in county hospitals and almost thirty percent of all

[3]Calculated from the numbers presented in the First Annual Report to the Health Care Financing Administration on the Selective Provider Contracting Program, Volume 2, p. 26.

Exhibit 6.1

OWNERSHIP STATUS OF CONTRACT AND NON-CONTRACT HOSPITALS

Ownership Status	Contract Hospitals** (n = 245)		Non-Contract Hospitals** (n = 90)	
	Number of Hospitals	Percent of Hospitals	Number of Hospitals	Percent of Hospitals
Non-Profit	116	47%	39	43%
Proprietary	75	31%	46	51%
County	21	9%	0	0%
City/County/District[a]	27	11%	5	6%
University of California[b]	6	2%	0	0%
		100%		100%

**Difference in distribution by ownership type between contract and non-contract hospitals is significant at the .01 level as measured by chi-square.

[a]Hospitals that are either owned by a district or jointly owned by a county and city are included in this category.

[b]One psychiatric hospital that is part of the University of California hospital system is included in this group.

Exhibit 6.2

PERCENTAGE OF TOTAL REVENUES PAID BY PAYER
FOR CONTRACT AND NON-CONTRACT HOSPITALS BY OWNERSHIP STATUS

	Contract Hospitals	Non-Contract Hospitals
All Groups	(n = 242)	(n = 85)
% Medi-Cal Revenues	19%	11%**
% Medicare Revenues	37%	39%
% Other Payer Revenues	44%	50%**
Non-Profit	(n = 114)	(n = 37)
% Medi-Cal Revenues	15%	8%**
% Medicare Revenues	38%	42%*
% Other Payer Revenues	47%	50%
Proprietary	(n = 74)	(n = 43)
% Medi-Cal Revenues	17%	12%+
% Medicare Revenues	38%	38%
% Other Payer Revenues	45%	51%+
City/County/District	(n = 27)	(n = 5)
% Medi-Cal Revenues	15%	23%
% Medicare Revenues	43%	28%**
% Other Payer Revenues	43%	48%
County	(n = 21)	(n = 0)
% Medi-Cal Revenues	46%	---
% Medicare Revenues	23%	---
% Other Payer Revenues	31%	---
UC	(n = 6)	(n = 0)
% Medi-Cal Revenues	29%	---
% Medicare Revenues	23%	---
% Other Payer Revenues	48%	---

NOTE: **Differences between contract and non-contract hospitals are significant at the .01 level.

*Differences between contract and non-contract hospitals are significant at the .05 level.

+Differences between contract and non-contract hospitals are significant at the .10 level.

[a]Hospitals that are either owned by a district or jointly owned by county and a city are included in this category.

revenues in UC hospitals.

Thirty-one percent of all contract hospitals are investor owned, representing only 62 percent of all proprietary hospitals. Half of the hospitals that did not seek or were not awarded contracts were investor owned, even though 12 percent of their revenues were paid by Medi-Cal. These non-contract proprietary hospitals were willing to rely on Medicare, other payers, and PPO contracts to support them. Note that despite these trends, the majority of contracts, were awarded to non-profit hospitals. Forty-seven percent of the contract hospitals are non-profit, accounting for 75 percent of the non-profit hospitals.

In general, contract hospitals are more dependent on Medi-Cal revenues than non-contract hospitals (Exhibit 6.2). Not surprisingly, contract hospitals had significantly more revenues paid by Medi-Cal than non-contract hospitals in fiscal year 1981-1982. Medi-Cal revenues were, on average, 19 percent of total revenues in contract hospitals while non-contract hospitals received, on average, only 11 percent of their revenues from Medi-Cal.

On the other hand, non-contract hospitals relied more heavily on non-government payers than contract hospitals in the fiscal year prior to contracting. Fifty percent of the revenues in non-contract hospitals were paid by other payers, whereas significantly less (44%) was paid by non-government payers in contract hospitals. The percentage of revenues paid by

Medicare was similar between the two types of hospitals. About 40 percent of all revenues was paid by Medicare in both contract and non-contract hospitals. This pattern is generally observed across all ownership types.

The percentage of hospitals in each peer group is not significantly different between contract and non-contract hospitals. Nevertheless, it is interesting to note the distribution of hospitals among peer groups. Exhibit 6.3 displays the number and percentage of contract and non-contract hospitals by peer group classification. Over half (58%) of the contract hospitals are small urban or moderate sized hospitals. Another 20 percent are classified as large complex hospitals. This distribution is not very different for non-contract hospitals. However, all the university teaching and non-university teaching hospitals (except for one) received contracts. In part, this can be explained by the fact that 60 percent of all the teaching hospitals are county or UC facilities. The remaining 40 percent of the teaching hospitals are non-profit or jointly owned by a city and county.

Not surprisingly, the principal type of service is similar between contract and non-contract hospitals. Contracting exempted certain specialty and children's hospitals, leaving general acute, psychiatric, and other non-exempt (i.e., rehab, respiratory, chemical dependency, etc.) hospitals eligible for contracting. Furthermore, GOSHN stopped contracting for psychiatric services after the first month of contracting. As a result, 95 percent of the contract hospitals principally provide general medical and surgical services. Only one percent of the contract hospitals principally provide psychiatric services. Another four percent cite the other non-exempt services as their principal service. Non-contract hospitals show a similar pattern. In addition, licensed occupancy and bed size reveal no differences between contract and non-contract hospitals. The average occupancy rate for both

Exhibit 6.3

PEER GROUP OF CONTRACT AND NON-CONTRACT HOSPITALS

Peer Group	Contract Hospitals (n = 244) Number of Hospitals	Contract Hospitals (n = 244) Percent of Hospitals	Non-Contract Hospitals (n = 89) Number of Hospitals	Non-Contract Hospitals (n = 89) Percent of Hospitals
University Teaching	8	3%	0	0
Large, Non-University Teaching	12	5%	1	1%
Large Complex	49	20%	22	25%
Moderate-Sized	64	26%	28	31%
Small Urban	78	32%	30	34%
Rural	8	3%	1	1%
Other[a]	25	11%	7	8%
		100%		100%

NOTE: Differences between contract and non-contract hospitals are not significant.

[a]The 'other' category includes urban and rural skilled nursing facilities, moderate and acute psychiatric hospitals, and other types of facilities.

types of hospitals is about 60 percent. The majority of contract and non-contract hospitals are moderate sized (50-300 beds). About 20 percent of the contract hospitals are larger than 300 beds.[4]

6.2 Contract Rates

As mentioned previously, there were a total of 335 hospitals eligible to receive contracts in HFPAs in which GOSHN negotiated. During the period from February through August, 1983, hospitals in each HFPA were grouped into cohorts for negotiating purposes. For example, all the Sacramento hospitals (HFPA 311) were in the first cohort and negotiated with GOSHN in February, the first month of contracting. San Francisco initially negotiated with the state in February, but because of the litigation resulting from the rejection of bids from the three largest hospitals in the city, San Francisco was renegotiated in July. For this analysis, San Francisco was excluded from the February cohort and given its own cohort to control for the confounding effects of the unique circumstances surrounding the San Francisco negotiations.

As discussed in Chapter Four, GOSHN had an explicit goal to contract with as many hospitals as possible. The proportion of eligible hospitals receiving contracts is shown in Exhibit 6.4. Overall, 73 percent of all the eligible hospitals received contracts, accounting for about 86 percent of the historical non-MIA expenditures. However, the percentage of hospitals awarded contracts varies by cohort.

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[4]Attachment D describes the methodology used in this chapter. (Exhibits D.1 and D.2 in Attachment D display the principal service, bed size, and occupancy rates for contract and non-contract hospitals).

Exhibit 6.4

NUMBER AND PERCENT OF ELIGIBLE HOSPITALS RECEIVING CONTRACTS BY COHORT

Cohort	General Area of HFPAs	Percent of Historical Medi-Cal[a] Expenditures	Number of Eligible Hospitals	Number of Hospitals Receiving Contracts	Percent of Hospitals Receiving Contracts
February[b]	Daly City Sacramento Long Beach Lynwood San Diego	14.8%	42	33	79%
March	East Bay Santa Clara	10.8%	28	18	64%
April	San Fernando Valley San Gabriel Valley Los Angeles La Canada San Diego North-County	28.3%	116	76	65%
May	Orange County	4.9%	24	13	54%
June	Merced Modesto Central Valley Santa Cruz San Luis Obispo San Bernardino-Metro	6.9%	38	37	97%
July	Central Valley Oxnard Lancaster Contra Costa County Riverside San Bernardino County San Diego North-City	12.7%	62	46	74%
San Francisco[c]	San Francisco	6.2%	15	14	93%
August	Susanville Fairfield Bakersfield Banning	1.6%	10	8	80%
Total		86.2%	335	245	73%

[a]Excludes MIA and Medicare-cross-over expenditures.

[b]As a result of the unique circumstances surrounding the San Franciso negotiations, San Francisco is excluded from the February cohort and given its own cohort.

[c]The figures represent the results from the renegotiations in July.

GOSHN generally chose to negotiate first in HFPAs with relatively high Medi-Cal expenditures leaving the areas with the lowest Medi-Cal expenditures for the last month. The first group of hospitals to negotiate with GOSHN accounted for about 15 percent of historical Medi-Cal expenditures, the second highest percentage among the cohorts.[5] Given the high participation rate in the Medi-Cal program it is not surprising to find that 79 percent of the hospitals in the February cohort received contracts. However, the group of hospitals with the largest Medi-Cal expenditures negotiated in the third month of contracting, April. Twenty-eight percent of the Medi-Cal payments went to hospitals in the HFPAs in the April cohort. Los Angeles alone accounted for 13 percent of the expenditures. Only 65 percent of the hospitals were awarded contracts. However, almost half of all the proprietary hospitals were included in this cohort, accounting for the lower percentage of hospitals receiving contracts.

Virtually all the hospitals in San Francisco received contracts after the renegotiations in July. The first time that San Francisco negotiated with the state, only 10 of the 15 hospitals, or 67 percent, received contracts, excluding three of the largest hospitals. Litigation by these three hospitals prompted Guy to reopen the area for bidding. As a result, all the acute care hospitals in San Francisco received contracts.

Similarly, all but one of the hospitals in the June cohort were awarded contracts. It appears the reason for such a high percentage is that these HFPAS include sparsely populated communities. GOSHN had to contract with a larger number of hospitals to meet community travel time standards and service needs.

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[5]If San Francisco hospitals are added to the February cohort, the historical percentage of ##?Medi-Cal expenditures is even higher -- 21 percent.

The May cohort, representing only five percent of historical Medi-Cal costs, received the lowest percentage of contracts. About half of the hospitals in Orange County were awarded contracts. There were fewer hospitals in Orange county that sought contracts because of the low number of Medi-Cal recipients in the area.

The negotiations not only focused on which hospitals did or did not receive contracts. The types of rates were crucial bargaining chips. Guy explicitly told hospitals at the introductory meeting his strong desire for a per diem rate, rather than a per-discharge rate. He further encouraged that the per diem rate cover all services that the hospital generally provided.

Guy's preference clearly influenced the types of rates that were negotiated. Eighty-four percent of the hospitals negotiated an all inclusive per diem rate (Exhibit 6.5). The other 16 percent of the hospitals negotiated alternative rates. Five different types of alternative rates were agreed upon. Hospitals with needed specialty services had the leverage to negotiate separate per diems for individual services such as perinatal, ICU, or burn services. In addition, GOSHN negotiated separate rates for psyshiatric services during the first month of contracting but discontinued this practice during the remainder of the negotiations. Altogether, 8 percent of the hospitals negotiated separate rates for specific services. Another group of hospitals (6%) based their per diems on the number of patient days. For example, one hospital agreed to a rate of $525 a day for the first 10,000 Medi-Cal days provided, and a volume discount to $515 a day thereafter. Two hospitals negotiated per diems based on the timeliness of payment -- $500 a day if the claim is paid within 65 days, otherwise the state would pay $520. Contrary to Guy's preference for per diems, two hospitals negotiated discharge

Exhibit 6.5

TYPES OF RATES NEGOTIATED

Rate Type	Number of Hospitals	Percent of Hospitals
All-Inclusive Per diem	206	84%
Per diem Rates for Individual Services	20	8%
Per diems Based on the Number Patient Days	14	6%
Per diems Based on Payment Timeliness	2	1%
Per Discharge	2	1%
Other	1	--
	245	100%

rates. However, CMAC indicated that discharge rates were not easily administered. In fact, one of the two hospitals later renegotiated a per diem rate.

The level of the rate was, by far, the most important aspect of the negotiations. Hospitals which did not meet GOSHN's rate expectations did not receive contracts. The per diems that were agreed upon were considerably less than what the hospitals had been paid previously.

Average per diems, converted to constant dollars, were calculated for the one year prior to contracting and for the first eight months under contracting (until September 1983).[6] The per diems before contracting are based on interim payments prior to audit settlements. After these reconciliations, DHS estimates that the per diems decrease by an average of 8 percent. Since settlement data were available for less than 20 percent of the hospitals, the interim rates calculated from the hospital claims for this report are not adjusted for the settlements.

Comparing the per diems paid before and after contracting reveals a striking, but not unexpected, result. The per diems paid to contracting hospitals significantly decreased between time periods while the per diems paid to non-contract hospitals significantly increased during the same period. As Exhibit 6.6 indicates, the average per diem paid to contract hospitals prior to contracting was $626. After implementation, contracting per diems decreased to $541. Medi-Cal rates were essentially rolled back by

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[6]Thus, the per diems are averaged across eight months for a hospital that negotiated a rate in February. Similarly, a hospital in the July cohort would have only submitted three months of bills under contracting, with an average per diem based on three months. In addition, the hospital claim payments were adjusted for inflation using the same inflation factors employed by the Fiscal Forecasting Section in DHS. The per diems presented in this analysis represent January, 1983 dollars. The analysis uses month-of-service data.

Exhibit 6.6

MEDI-CAL PER DIEMS BEFORE AND AFTER CONTRACTING
FOR ALL HOSPITALS, CONTRACT HOSPITALS, AND NON-CONTRACT HOSPITALS[a]

	Per diems Before Contracting	Per diems After Contracting	Percent Change
All Hospitals	$624 (n=332)	$544 (n=317)	-12.8%**
Contract Hospitals	$626 (n=244)	$541 (n=242)	-13.6%**
Non-Contract Hospitals	$603 (n=88)	$757 (n=75)	+25.5%**

NOTE: **Differences between the per diems before and after contracting are significant at the .01 level.

[a]Month of service hospital claims for the twelve months prior to contracting were averaged to calculate the pre-contracting per diems. These per diems prior to contracting represent interim Medi-Cal payments before audit settlements. Claims for the first eight months under contracting (up to September 1983) were averaged to calculate the per diems after contracting. The per diems are weighted by the number of Medi-Cal general acute care patient days to best reflect changes in Medi-Cal outlays. However, the sample sizes are unweighted counts of hospitals. The sample sizes may differ between time periods because of the frequency of claim submissions. A few hospitals had not yet submitted a claim between the onset of contracting and September 1983. The unweighted mean per diems are presented in Attachment D. All per diems have been converted to constant dollars as of January, 1983.

14 percent.[7] In contrast, non-contract per diems averaged $603 before contracting and increased to $757, a 25.5 percent increase. Admissions arising from emergency services account for the considerable increase in non-contract per diems. Non-contract hospitals are paid under the same system in effect for HFPAs not subject to contracting. Despite the substantial increase in per diems among the non-contract hospitals, the state still experienced an overall initial rate reduction of 12.8 percent.

There were also differences in rate reductions realized by month of negotiation. Exhibit 6.7 presents the average contract per diems before and after contract implementation by cohort. GOSHN expected the greatest savings from the ubran areas which typically had larger numbers of hospitals, higher rates, more excess capacity, and a higher concentration of Medi-Cal recipientes. In short, these were the areas with the greatest potential competition for Medi-Cal contracts. Accordingly, GOSHN chose to negotiate these areas first. And, in fact, GOSHN achieved the greatest rate decreases in the first four months of negotiations. The negotiated rates for the February, March, April, and May cohorts averaged 16.8 percent less than the rates paid before contracting. The greatest rate reduction was achieved in the second group of hospitals in the East Bay and Santa Clara. Los Angeles hospitals also experienced high rate decreases. The rate reductions were substantially less for the June, July, and August cohorts, averaging only 5.4 percent. For the most part, HFFAs in these cohorts represent less urban areas with lower Medi-Cal recipients than the HFPAs in the earlier cohorts. The

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[7]Assuming that per diems decrease by an average of 8 percent after audit settlements, the change in per diems after contract implementation would represent a 6 percent decrease. Reconversion of these figures to actual dollars (as opposed to constant dollars) would result in a further decrease in the percentage magnitude of the roll-back.

Exhibit 6.7

MEDI-CAL PER DIEMS BEFORE AND AFTER CONTRACTING BY COHORT FOR CONTRACT HOSPITALS[a]

Cohort	General Area of HFPAs	Before Contracting	After Contracting	Percent Change
February[b]	Daly City Sacramento Long Beach Lynwood San Diego			
March	East Bay Santa Clara	$650 (n=139)	$541 (n=138)	-16.8%**
April	San Fernando Valley San Gabriel Valley Los Angeles La Canada San Diego North-County			
May	Orange County			
June	Merced Modesto Central Valley Santa Cruz San Luis Obispo San Bernardino-Metro			
July	Central Valley Oxnard Lancaster Contra Costa County Riverside San Bernardino County San Diego North-City	$560 (n=91)	$529 (n=90)	-5.4%**
August	Susanville Fairfield Bakersfield Banning			
San Francisco[c]	San Francisco	$648 (n=14)	$598 (n=14)	-7.7% +

+Differences between the per diems before and after contracting are significant at the .01 level.

**Differences between the per diems before and after contracting are significant at the .01 level.

[a]Month of service hospital claims for the twelve months prior to contracting were averaged to calculate the pre-contracting per diems. These per diems prior to contracting represent interim Medi-Cal payments before audit settlements. Claims for the first eight months under contracting (up to September 1983) were averaged to calculate the per diems after contracting. The per diems are weighted by the number of Medi-Cal general acute care patient days to best reflect changes in Medi-Cal outlays. However, the sample sizes are unweighted counts of hospitals. The sample sizes may differ between time periods because of the frequency of claim submissions. A few hospitals had not yet submitted a claim between the onset of contracting and September 1983. The unweighted mean per diems are presented in Attachment D. All per diems have been converted to constant dollars as of January, 1983.

[b]As a result of the unique circumstances surrounding the San Francisco negotiations, San Francisco is excluded from the February cohort and given its own cohort.

[c]The figures represent the results from the renegotiations in July.

state realized a 7.7 percent rate reduction in San Francisco after the renegotiations.

The reduction in contract per diems also varied by ownership, peer group classification, and the type of rate that was negotiated. Exhibit 6.8 presents the per diems paid to contract hospitals before and after contract implementation by ownership status and peer group. The magnitude of the reduction experienced by the University of California hospitals is very large -- GOSHN negotiated a 20 percent rate reduction among these hospitals. Before contracting, UC costs were as high as $815 a day; the average rate after contracting was $651. The UC hospitals' costs were considerably higher than other hospitals' costs, giving GOSHN more flexibility in the negotiations. The rate reduction in investor owned hospitals was also significant. Despite their lower costs prior to contracting, rates for proprietary hospital were reduced by 17 percent. GOSHN negotiated only the average rate decrease for non-profit and county hospitals -- about 13 percent.

Examining the per diems by peer group also shows significant differences between the rates paid prior to and after contracting. GOSHN negotiated the greatest reduction in rates among the teaching hospitals. Teaching hospitals, with the highest initial rates, experienced about a 17 percent decrease in their rates. While the rate decreases among the other peer groups are significantly different between time periods, GOSHN achieved less than average reductions -- about 11 percent.

In addition to peer group and ownership differences, the reduction in rates differed by the type of rate that was negotiated. Recall that the predominant type of rate was the all-inclusive per diem but that 16 percent of the hospitals negotiated alternative rates. Exhibit 6.8 also shows the rates paid before and after contracting for hospitals negotiating each type of

Exhibit 6.8

MEDI-CAL PER DIEMS BEFORE AND AFTER CONTRACTING BY OWNERSHIP STATUS, PEER GROUP, AND RATE TYPE FOR CONTRACT HOSPITALS[a]

	Per diems Before Contracting	Per diems After Contracting	Percent Change
Ownership Status			
Non-profit	$603 (n=115)	$529 (n=113)	-12.3%**
Proprietary	$576 (n=75)	$480 (n=75)	-16.7%**
County	$654 (n=21)	$566 (n=21)	-13.5%**
City/County/District[b]	$509 (n=27)	$462 (n=27)	- 9.2%**
UC	$815 (n=6)	$651 (n=6)	-20.1%**
Peer Group			
University Teaching	$748 (n=8)	$614 (n=8)	-17.9%**
Non-University Teaching	$705 (n=12)	$587 (n=12)	-16.7%**
Large Complex	$594 (n=49)	$528 (n=49)	-11.1%**
Moderate-Sized	$552 (n=64)	$487 (n=64)	-11.8%**
Small Urban	$516 (n=77)	$462 (n=76)	-10.5%**
Other	$557 (n=33)	$495 (n=32)	-11.1%**
Rate Type			
All-Inclusive Per diem	$630 (n=205)	$533 (n=203)	-15.4%**
Alternative Rate[c]	$613 (n=39)	$572 (n=39)	-6.7%**

**Differences between time periods are significant at the .01 level.

[a]Month of service hospital claims for the twelve months prior to contracting were averaged to calculate the pre-contracting per diems. These per diems prior to contracting represent interim Medi-Cal payments before audit settlements. Claims for the first eight months under contracting (up to September 1983) were averaged to calculate the per diems after contracting. The per diems are weighted by the number of Medi-Cal general acute care patient days to better reflect Medi-Cal outlays. However, the sample sizes are unweighted counts of hospitals. The sample sizes may differ between time periods because of the frequency of claim submissions. A few hospitals had not yet submitted a claim between the onset of contracting and September 1983. The unweighted mean per diems are presented in Attachment D. All per diems have been converted to constant dollars as of January, 1983.

[b]Hospitals that are either ownded by a district or jointly owned by a county and city are included in this category.

[c]Alternative rates include rates based on the timeliness of payment or the number of patient days, discharge rates, and rates for separate services.

rate. GOSHN clearly achieved greater reductions by negotiating the all-inclusive per diem. The decrease for hospitals negotiating alternative rates was substantially less than the decrease experienced by hospitals negotiating all-inclusive rates. A 15 percent reduction was achieved for hospitals negotiating all-inclusive per diems while only a 7 percent decrease was negotiated by hospitals with alternative rates.

6.3 Contract Savings

As a result of the reductions in per diems, savings in the first eight months of contracting are substantial. The per diems that would have been paid in the absence of contracting were estimated for the first eight months under contracting using month of service hospital claims from July 1980 through September 1983.[8] These estimates are compared to the actual per diems paid under contracting between February and September 1983.[9] Differences in ownership status, peer group, cohort and other factors accounting for any variations in the per diems have been controlled.[10]

Exhibit 6.9 compares the actual per diems paid between February and September, 1983 to predicted rates that would have been paid in the absence of contracting. The rates paid under contracting were, on average $546 a day. If contracting had not been in effect, the rates are estimated to have been $680 a day, or 20 percent higher. Assuming that audit settlements decrease per diems by an average of 8 percent, the percent savings would be closer to 13 percent. Nevertheless, substantial savings were achieved in the first

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[8]Per diems increased by about $5 a day per month between July 1980 and September 1983, representing a 7 percent rate of growth in Medi-Cal costs.

[9]All per diems are expressed in constant dollars, as of January, 1983.

[10]Attachment D describes the methodology for estimating the per diems.

Exhibit 6.9

PREDICTED PER DIEM SAVINGS UNDER CONTRACTING
BY MONTH - FEBRUARY TO SEPTEMBER 1983[a]

Month	Predicted Per diem Payment	Actual Per diem Payment	Percent Change
February 1983	$648	$592	-8.6%
March 1983	$676	$562	-16.9%
April 1983	$679	$552	-18.9%
May 1983	$680	$554	-18.5%
June 1983	$675	$537	-20.4%
July 1983	$666	$538	-19.2%
August 1983	$696	$536	-23.0%
September 1983	$697	$539	-22.7%
Average	$680	$546	-19.7%**

NOTE: **Differences between actual and predicted per diems are significant at the .01 level.

[a]The per diems have been weighted by the number of Medi-Cal general acute care patient days to better reflect Medi-Cal outlays. Unweighted actual and predicted per diems are presented in Attachment D. All per diems have been converted to constant dollalrs as of January, 1983.

eight months of contracting.[11]

The savings varied by cohort. Exhibit 6.10 presents the actual and predicted per diem payments by cohort between February and September, 1983. Not surprisingly, the magnitude of savings parallel the reductions in rates discussed earlier. Payments to hospitals in the first four cohorts were estimated to be 21 percent higher if contracting had not been implemented. Payments to hospitals in the March and April cohorts account for the greatest difference between the predicted and actual payments. Similarly, the state would have paid almost 15 percent higher per diems to hospitals in the June, July, and August cohorts. Finally, payments to hospitals in San Francisco were predicted to have been 11 percent higher in the absence of contracting. The percent savings in per diems would have been higher in San Francisco had there not been renegotiations. Between February and July, San Francisco hospitals were paid the initial negotiated rate. However, after the renegotiations, GOSHN awarded contracts to all acute care hospitals in San Francisco, including three large expensive hospitals that had been previously excluded.

6.4 Aggregate Savings

As would be expected from the reductions in per diem payments achieved by contracting, the aggregate savings to the state (and to the Federal government) are quite large, even given some offsetting expenses such as high per diems in non-contracting hospitals and higher medical transportation costs. May 1984 DHS estimates of savings for fiscal year 1983-1984 were between $140 million and $165 million depending on whether an

[11]Note, the savings increased dramatically between the first month and second month, from 8.6 percent to 16.9 percent. This result is a function of several factors--most notably the fact that the hospitals in the second cohort had extremely high rates prior to contracting. Other factors include seasonal variations in predicted costs.

Exhibit 6.10

PREDICTED PER DIEM SAVINGS UNDER CONTRACTING
BY COHORT[a]
FEBRUARY - SEPTEMBER 1983

Cohort	General Area of HFPAs	Predicted Per diem Payment	Actual Per diem Payment	Percent Change
February[a]	Daly City Sacramento Long Beach Lynwood San Diego			
March	East Bay Santa Clara	$691	$543	-21.4%**
April	San Fernando Valley San Gabriel Valley Los Angeles La Canada San Diego North			
May	Orange County			
June	Merced Modesto Central Valley Santa Cruz San Luis Obispo San Bernardino			
July	Central Valley Oxnard Lancaster Contra Costa County Riverside San Bernardino County San Diego North-City	$619	$528	-14.7%**
August	Susanville Fairfield Bakersfield Banning			
San Francisco	San Francisco	$681	$604	-11.3%*

NOTE: **Differences between actual and predicted per diems are significant at the .01 level.

[a]The per diems have been weighted by the number of Medi-Cal general acute care patient days to better reflect Medi-Cal outlays. Unweighted actual and predicted per diems are presented again in Attachment D. All per diems have been converted to constant dollars as of January, 1983.

accrual or cash accounting basis was used. Subsequent year savings estimates were higher.

DHS calculates two savings estimates for each fiscal year--a date of payment estimate and a date of service estimate. Each savings estimate is an estimate of the difference between what would have been paid under the previous Medi-Cal system and what will be paid under contracting. The difference between the two savings estimates is equivalent to the difference between a cash and an accrual accounting basis. Specifically, the date of payment estimates focus on the changes in inpatient hospital payments over the specified period while the date of service estimates focus on the savings accumulated for dates of services in that period. For example, a date of payment estimate for June would estimate changes in the amount paid out in June. A date of service estimate would focus on changes in the amount paid for services provided in June regardless of when the actual payments were made.

Date of payment and date of service estimates differ for two major reasons. First, bills for services lag between three and six months behind the actual date on which services are provided. Consequently, the payments in any given month relate to services provided between three and six months earlier. As a result, in the first few months of contracting, payments were still being made for services provided under the previous system. Hence, though savings had been accrued, they did not generate payment reductions in those months.

Under the previous Medi-Cal reimbursement system, the actual payments to hospitals were made on the basis of interim rates; final rates, and the resulting settlement, were typically not resolved until several years after the close of the hospital's fiscal year. The state estimates that final

rates are between seven and eight percent less than interim payments. Under contracting the contract rate is the final rate and, accordingly, there is no settlement. This means the state no longer allows what are in essence loans to hospitals (i.e. the amount which the hospital must pay back at the time of the settlement). Elimination of this "loan" decreases cash outflow and increases date of payment savings estimates.

As a result of these different effects, the relationship between date of payment and date of service aggregate savings estimates changes over the first three years of contracting. For each full year of contracting, however, both estimates are very large. Exhibit 6.11 shows aggregate savings estimated by DHS for date of payment and date of service for fiscal years 1982-83, 1983-84 and 1984-85. Fiscal year 1983-84, the first full year under contracting, shows date of payment (cash) savings of about $165 million and date of service (accrued) savings of about $140 million. These savings are measured against an estimated base of $1.1 billion in the absence of contracting. For fiscal year 1984-85, the savings estimates grow substantially to $218 million for date of payment (cash) and $236 million for date of service (accrued). As shown, these estimates take into account the effect of all settlements which would have been made against interim rates, as well as the costs of additional medical transportation added by contracting and changes in hospital-based physician reimbursement.

Before considering the methodology and accuracy of these methods, there are three major conceptual points which must be addressed:

* Assumptions underlying these estimates
* Probable revisions of these estimates
* Basis of comparison for determining savings.

One of the most striking features of the savings estimates shown in

Exhibit 6.11 is the huge growth in savings between fiscal years 1983-84 and 1984-85. Date of service estimates, for instance, grow from $140 million to $236 million. This savings growth between 1983-84 and 1984-85 assumes that there is no net contractual rate increases in those years, even though the amount which would have been spent in the absence of contracting continues to increase (since the previous reimbursement system allowed hospitals to automatically adjust their rates for inflation.) The result is that savings estimates increase as a function of time since contracting rates are held constant while inflation pushes up what would have been spent under the old system. Although it is not clear that CMAC can avoid making any rate increases during the second year, it is important to understand that as long as the rate of increase under contracting is less than the rate of hospital inflation expected under the old system, the state's methodology will show continually growing savings. Since the manner in which contracting was established gives the state enormous power in controlling rates, (see Chapter 10) it seems likely that the savings will increase dramatically in future years.

It is unlikely, however, that the growth of savings will be quite as large as estimated by DHS. At this writing, it does not appear that CMAC can completely avoid all rate increases affecting fiscal year 1984-85. If there are some additional rate increases, these will probably be small and the decline in date of payment savings will not be significant; the impact on date of service savings will be larger. On the other hand, there may some increases in savings estimates as a result of new utilization estimates, although these will not be large.[12]

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[12]Generally speaking, when utilization declines, the savings estimates also decline because the aggregate savings estimates are essentially

Exhibit 6.11

DHS SAVINGS ESTIMATES FROM HOSPITAL CONTRACTING
(in millions)
May, 1984

	A. Unadjusted Savings Against Interim Rates	B. Settlement Recoveries Foregone	C. Hospital Based Physician Changes	D. Increased Medical Transportation Costs	E. Net[a] Total
		Date of Payment (Cash Flow)			
1982-83	$12.5	(.2)	0.0	(.1)	$12.2
1983-84	$179.5	(13.8)	0.1	(.5)	$165.2
1984-85	$297.9	(79.7)	0.4	(.4)	$218.2
		Date of Service (Accrual)			
1982-83	$44.0	(17.3)	0.0	(.2)	$26.6
1983-84	$222.7	(81.9)	0.2	(.5)	$140.4
1984-85	$333.8	(97.9)	0.4	(.4)	$235.9

[a]Total of previous four columns (A through D)
Rows may not sum exactly due to rounding errors.

A final conceptual issue concerns the standard against which these savings are measured. The savings shown in Exhibit 6.11 reflect savings which would have occurred had the previous reimbursement system continued. Other bases of comparison are plausible. For instance, it is possible to measure savings not against the previous system, but against the peer-group system which is in effect for most hospitals not under contracting.[13] If the peer grouping reimbursement system were used as a basis of comparison, the resulting savings would be much smaller. For instance, DHS estimates that FY 1983-84 date of payment savings would be $45 million less and date of service savings would be $66 million less. In other words, had the peer grouping system been applied to the hospitals under contracting, it would have resulted in savings of $45 and $66 million respectively. In general, the degree of savings is highly dependent on the base of comparison, a choice which is often subject to debate.

Similarly, it should be kept in mind, that the savings realized by contracting could potentially have been realized by other methods (e.g., a 10 percent rate rollback, an even tighter peer grouping system, or a stringent DRG system). Analysis of cost containment mechanisms often loses sight of the fact that the payment methodology does not in itself determine the level of payment. Certain methodologies may lend themselves more or less to cost containment, but the savings are determined by how the methodology is

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calculated by multiplying the savings per day. If the estimates of the number of days decline, the savings decline. The May DHS saving estimates (shown in Exhibit 6.11) were about $10 to $12 million lower than previous savings estimates because of an adjustment to better account for changes in the way in which nursery days were being counted. It appears that DHS savings estimates for later in 1984 will increase because of a belief that utilization is increasing slightly faster than previously predicted.

[13]For a further discussion of the peer-group reimbursement system, see Chapter Four.

implemented, particularly including exogenous policy decisions which set reimbursement parameters, such as the Congressional mandate of budget neutrality for PPS or the California General Assembly's less formal mandate to GOSHN to save $200 million. Choice of a particular methodology is therefore determined more by political or administrative expediency, equity issues or philosophical preference than by savings potential alone. The savings potential is tremendously influenced by this larger context and evaluation of reimbursement methodologies must give equal weight to the contextual issues.

After a careful review of the DHS savings estimates, AAI concluded that a complete replication was not necessary, particularly given the similarity of results to the per diem analysis reported earlier in this chapter. Our review, which included certain mathematical checks designed to test the application of the model, suggested that although the savings estimates are certainly of the correct order of magnitude, there are some problems with the state's methodology. Nevertheless, the net impact of our differences with the state methodology is small. Attachment E contains a detailed review and critique of the state's methodology for estimating savings.

Finally, the methodology used by the state has been very carefully constructed to ensure that estimates of savings from contracting are reasonably isolated from savings generated by the change in the definition of medical necessity and the MIA changes. This is accomplished by excluding any MIA expenditures from both the pre- or post-contracting period and by basing volume projections on the period after the change in medical necessity. Thus, although several respondents had suggested they felt the state's savings estimates included savings from these other changes, we are confident the

state's methodology makes a fair estimate of the savings resulting from contracting *per se*..

CHAPTER 7

IMPACT ON PATIENTS

This chapter considers the impact of contracting on patient care quality and access. The impacts on recipients of the two other major changes included in AB 799--the change in the definition of medical necessity and the transfer of the MIA program to the counties--are also briefly discussed.

7.1 General Quality of Care

Our study did not include direct observation of patient records or direct sampling of patient attitudes. Both of these were rejected as too costly for the likely benefit, particularly in the absence of widespread allegations about the impact on patients. Our strategy, rather, consisted of asking informed observers and participants if they were aware of or had reasons to suspect problems in quality of care. Respondents consistently indicated that they did not know of major systematic problems with contracting, per se.[1] We will include a more direct investigation of quality issues in our quantitative analysis, as these responses can not be taken as proof that there are no quality problems. However, in the short run our findings suggest that contracting has not caused major problems for recipients.

[1]They did, however, have many unfavorable comments on other aspects of AB 799.

7.1.1 Perceptions of Advocacy Groups

Neither the California Hospital Association (CHA) nor the California Medical Association (CMA) felt that the contracting program had created major hardships for patients.

CHA had conducted some studies on the availability of special services and found some problems (see below) but many of these were addressed by the recontracting in San Francisco. They had also conducted extensive interviews with the medical staffs of 20 hospitals for information on changes as a result of contracting. Most medical staff members seemed to think that contracting had little impact on the quality of care which was being delivered. (CHA's summary statement of this study are included as Appendix B). CHA staff did, however, indicate concern about the long run effects of ratcheting down costs. "Hospitals have made most of the cuts they can without actually reducing patterns of service," one respondent said. They also said that the state's procedures for changing from fee-for-service to contracting were so incomplete that major problems were avoided only because of extraordinary efforts by hospitals to work out procedures for informing patients of the new system and arranging transfers of patients from noncontract to contract hospitals. These issues were particularly acute in San Francisco, since it was the first large city phased in.

CMA, both in discussions with us and in testimony before the Assembly Health Committee, stated that their "worst fears" about contracting had not come to pass and, in fact, they did not think there were major adverse effects. They did, however, suggest that the primary reason problems were avoided was because such a large percentage of hospitals received contracts. CMA was concerned about what would have happened in San Francisco had not the area been reopened.

Attitudes of consumer groups about quality impacts were generally more cautious than those of the trade associations, but they could point to few major specific problems. Specific concerns raised by consumer groups included the decrease in the number of translators available in some areas, decreased availability of outpatient services due to contracting, and general concern over cut backs in medical care. There was also some concern that contracting had not made a sufficient attempt to exclude poor quality institutions and that, in the long run, it would be beneficial to proprietary hospitals because they were more willing to cut quality of care than non-profit hospitals.

7.1.2 State Monitoring of Quality

The state has three major mechanisms for monitoring quality of care under the contracting program. First, incident reports are filed in or by the local DHS field offices and centrally monitored by the Hospital Contract Coordinating Unit as described in Chapter 3. Second, DHS formed special Program Evaluation Teams to undertake a series of studies. Finally, special state inspections determine if Medi-Cal recipients are given a lower level of care. None of these monitoring mechanisms have, as yet, identified major patient-related problems with contracting.

Incident reports are filed, primarily, by field offices, although they may be filed directly by patients or other groups with the DHS Hospital Contract Coordinating Unit in Sacramento. Incidents are logged into the system and a medical consultant reviews each complaint and makes an initial decision on a course of action. Some incidents require an on-site investigation by a special medical investigation team formed by the DHS contract office.

Exhibit 7.1 contains a summary of incident reports as of June 30, 1984 furnished to us by DHS. It shows almost 532 incidents reported (which raise a total of 672 issues) in one year of contracting. Almost seventy percent of the reported incidents involved emergency room treatment and transfer problems. Fifteen percent of the incidents were connected to other admission problems. About twelve percent of the incidents cited inadequate or unsatisfactory quality of care rendered to patients. While these results raise the possibility of wide-spread problems, DHS claims that the number of reported incidents overstates the magnitude of actual problems. Exhibit 7.2 shows the results of resolved incidents as of June 30, 1984. However, these represent only one-third of the reported incidents. The other two-thirds were still under investigation. Of the 239 for which findings had been made, only 23 were determined to involve contract violations requiring warning letters to the offending hospitals. Subsequent violations will result in DHS halting payments to the facility and initiating termination procedures.[2] In the remaining 216 resolved incidents, DHS determined the hospital acted appropriately within the terms of the hospital's contract. DHS also claims that the backlog of unresolved incidents has been reduced and that no major problems have been uncovered. However, this backlog has remained constant during the period of contracting despite continual claims that it is being reduced.

The Program Evaluation Teams (PETs) were originally created to undertake an extensive audit of financial and medical record information in the majority of hospitals in two very large HFPAs. However, after doing a small number of hospitals in the two selected regions, the PETs recommended

[2]Through July, 1984 no termination procedures had been initiated against hospitals, although at various times since the onset of contracting, individual hospitals had been subject to special monitoring.

Exhibit 7.1

Incident Report Statistics[a]
July 1, 1983 through June 30, 1984

Issue	Total Issues	Percent	Confirmed Violation	Percent
Admission	101	15.0%	18	21.2%
Emergency Room Treatment/Transfer	365	54.3%	49	57.6%
Transfer	104	15.5%	10	11.8%
Physician Activities	2	.3%	0	0%
Emergency Services	35	5.2%	2	2.4%
Appropriate Services	7	1.0%	0	0%
Transportation	4	.6%	1	1.2%
Quality of Care	38	5.7%	5	5.8%
Other	16	2.4%	0	0%
Total	672	100%	85	100%

[a]Source: Medi-Cal Operations Division. Although 672 issues were reported, only 532 actual incident reports were filed with the Department.

Exhibit 7.2

Resolved Incidents[a]
July 1, 1983 through June 30, 1984

Action Taken	Number Incidents	Percent
No Action Necessary	168	70%
Inquiry and No Further Action	44	18%
Clarifying Letter Sent	4	2%
Warning Letter[b]	23	10%

[a]Source: Medi-Cal Operations Division.

[b]Two situations also required submission by hospital of correction plan of action.

decreasing the sample in those HFPAs and, instead, investigating two additional HFPAs. Apparently, the samples were abbreviated in the first two regions because of lack of negative findings.[3] There is, however, continuing discussion in DHS concerning the possibility of making the PETs ongoing procedure.

Finally, special DHS teams investigating the possibility that hospitals were offering a lower level of care to Medi-Cal patients than to others have consistently failed to find a problem in this area. Although the methodology used by these teams is weak--medical records for two Medi-Cal recipients are subjected to a detailed comparison with two non-Medi-Cal recipients--this finding is consistent with the impression of the medical community. Moreover, there is no convenient way to discriminate against patients if they are not segregated into special wards. (Most nurse respondents--other than those with specific Utilization Review responsibilities--indicated that they did not know which patients were Medi-Cal and which were not. Consequently, they were somewhat puzzled by the state survey.) It is not clear this state survey is necessary as long as hospitals do not have mechanisms for segregating Medi-Cal recipients.

7.2 Access To Care

One of the major concerns prior to the implementation of contracting program was that the program would drastically reduce the number of hospitals serving Medi-Cal recipients and consequently limit access to care. This does not appear to be a major problem. In large part, of course, this is because most major Medi-Cal providers received contracts. Contracts were awarded to

[3]The PET reports were originally to have been released May 15, 1984; but were not released until September and copies have not yet been available to us.

hospitals which accounted for 85 percent of Medi-Cal historic utilization, so the potential amount of displacement was low. Moreover, the impact of not including hospitals in the Medi-Cal program would be indirect since patients do not generally choose their hospital, but rather go to the hospital to which their doctor refers them. Most doctors have, or can obtain, multiple affiliations, and with such a large percentage of contracting hospitals, physicians can refer their patient to a contracting hospital instead of a noncontracting hospital.[4]

In addition to continued general access, few hospitals reported difficulty in locating contracting facilities for transfer cases or specialized services. Likewise, most hospitals did not believe that high intensity cases were being "dumped" onto other hospitals. There was, however, some concern that access to outpatient services and physicians was becoming limited.

7.2.1 Transfers and Specialty Care

One indication of the degree of access is the experience of hospitals seeking to transfer Medi-Cal recipients. Transfers usually are necessary because a hospital is a non-contracting hospital or because the patient needs a service which the hospital does not provide. All hospitals in our sample had some experience transfering patients, although the tertiary hospitals typically transfered out very few patients because they in fact provide most services.

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[4]Medicaid patients in general may be more likely to choose a hospital directly because of difficulties in finding primary care. However, our respondents suggested that in California most non-emergency Medi-Cal admissions to private hospitals were made by private physicians rather than through the emergency room or clinic.

Many hospitals reported some minor problems, but the difficulty was not necessarily in locating a receiving hospital, but in making timely arrangements.[5] Examples of the problems cited included: a county hospital which was reluctant to accept transfers after 4:00 in the afternoon; particular paperwork problems in determining who would pay for the transfer in the case of delegated services; reluctance of the receiving hospital to accept a patient unless a work-up was done in sufficient detail that the receiving hospital could get the DHS prior approval before the patient arrived; and so forth. These delays were seen less as having negative impacts on the patients, than as having negative impact on the transfering hospital because of the resulting denial of days by the utilization review process, and consequent loss of revenue.

The lack of perceived problems in transfering patients needing special services suggests access to special services is in fact not the problem some predicted. A June, 1983 CHA study had suggested that while general access would be sufficient there was a potential shortage of specialized services in some areas. This study was based on California Health Facilities Commission data for fiscal years ending June 30, 1980 to June 29, 1981. Historic utilization data was used to estimate bed shortfalls for various services. The study assumed that hospitals would maintain their precontracting case load and that all vacancies in contracting hospitals would be filled by Medi-Cal recipients. Shortages of specialty services were predicted for several HFPAs. The largest and most serious shortage predicted by CHA was for neonatal intensive care services in San Francisco, but that was effectively

[5]Hospitals did, however, indicate that finding nursing homes to accept Medi-Cal patients at any time was a serious problem, particularly in Southern California.

solved when San Francisco was reopened for additional contracting negotiations.[6] Lesser problems were predicted for several other HFPAs.

Since our site visits only included two of the HFPAs where CHA predicted problems, it is not possible for us to make a definitive assessment of whether these problems materialized. They do not seem to have materialized in the HFPAs which we did visit. Part of this may stem from the CHA methodology for predicting these shortages. First, the predicted service shortfalls are based on projections involving assumptions which, while reasonable, particularly at the time of the study, may not be true. The most obvious concern is the assumption that overall volume would be maintained; all current evidence suggests that hospital volume is in fact decreasing. Likewise, the inability to separate out the utilization of MIA patients in determining original Medi-Cal utilization might also create noise, particularly in the coronary intensive care estimates.

Moreover, given the large number of contracts within urban areas like Los Angeles, the question of service availability by HFPA is of questionable relevance to access issues. At the time of their report, CHA observed that "in most areas [predicted] shortages can be absorbed by contract hospitals in nearby HFPAs." Availability of beds in nearby HFPAs probably provides access to care. It presumably makes little difference to a person who is going to have surgery whether the hospital is twelve minutes away or thirty-two minutes away. And emergency services are available at any hospital regardless of contracting status.

Distance may, however, be a factor in determining the number of visitors a patient will receive. This is particularly true in areas without

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[6]However, as reported in other sections, our respondents did not necessarily agree that there was a neonatal service shortage even under the original San Francisco configuration.

adequate mass transportation. It may also cause indirect problems in access to physicians. (i.e., clients may have to switch to physicians farther away who practice at a contracting hospital because their current physicians do not wish to move their practices.) The degree to which either of these, particularly the former, should be traded-off against cost savings in policy formulation is a validly debatable point.

A final point related to special services, was the concern that contracting might eventually put pressure on hospitals with more specialized services since those hospitals might not be able to compete on price alone with hospitals with less complex case mixes.[7] At least in the short run this does not seem to be a problem. Tertiary hospitals generally received contracts. Whether this will become a long run problem remains to be seen.

The issue of special service availability is one which we will address in a more detailed fashion in the next report when patient claim level information is available.

7.2.2 "Dumping"

One implication of the particular contracting strategy chosen by GOSHN was that the per diem rates do not generally vary by patient condition. Some critics feared that hospitals would respond to this situation by trying to avoid patients with more complicated medical conditions. This avoidance would be reflected in transferring more severe patients to other hospitals, or, "dumping" them, as the practice is often called.

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[7]This concern was one of the few concerns about the impact of contracting on patients voiced by legislators or legislative staff. In general, legislators and legislative staff indicated they were pleasantly surprised by the general lack of constituent complaints which they received about contracting, particularly in contrast to other provisions of AB 799 about which they had received many constituent complaints.

None of the hospital respondents in our sample thought that the level of dumping had increased as a result of contracting. One of the large county hospitals in our sample believed that some cases were dumped on them, but that this was more related to historical practice and utilization review procedures than to the adoption of contracting. This hospital believed that many of these transfers were not because the patient had severe medical problems, but because of the patient's social condition. In some cases, these were simply undesirable patients (e.g., alcoholics, deinstitutionalized mental health patients, etc). In other cases the transfer was because the patient's medical condition was not severe enough to receive continued approval from the state, but his or her home environment was such that discharge was inappropriate. Since the county is by law the provider of "last resort," our respondents indicated the county was obligated to provide care for this patient, even if the state would not pay. Therefore, community hospitals which did not have the same obligations would try to transfer the patient there. This hospital said it accepted some patients in this situation, but rejected others.

Several other hospitals mentioned cases of occasional dumping but were also reluctant to link them to contracting. Several references were made, for instance, to hospitals whose emergency rooms became "mysteriously filled" every Friday and Saturday night.[8] It was the general contention of hospitals that volume, private as well as Medi-Cal, had decreased so much in recent months, that hospitals were reluctant to transfer any patient, Medi-Cal and other, they could legitimately keep.

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[8]Weekend admissions are disliked by California hospitals because, first, they staff-down considerably on weekends; and, second, the Medi-Cal approval process is not available on the weekend and the hospital feels it is forced to gamble on whether or not the reviewers will allow the admission when it is reviewed on Monday.

In contrast, personnel in two of the five field offices visited thought dumping was a significant problem. However this perception was not generally supported by the special medical teams sent out by DHS to follow up incidents. As reported above, the majority of the disposed incidents resulted in a finding of no contract violation. Many contracts contain provisions which allow hospitals to limit their risk, but at the same time, cause many of these contract allowable incidents (e.g., hospitals included a clause that allowed the hospital to refuse Medi-Cal patients if 90 percent of the beds are full). The pattern found by the inspection teams sent by DHS is more consistent with the hospitals' perception of the issue: occasional violations, but not a major or systematic problem. When queried about this apparent discrepancy, field office personnel in at least one case said they did not agree with the special investigators but did not feel sufficiently comfortable with the terms of the contracts to pursue the issue further.

Part of the concern about patient dumping arises from a residual uncertainty about what services hospitals are really obligated to provide. Initially, hospital contracts were not available in field offices and it was extremely difficult for field office personnel to know whether or not a hospital was meeting its contractual terms. The situation was further confused by the fact that the state initially intended to hold contracting hospitals responsible for all services. Although they were unable to actually contract with hospitals on this basis, the perception remained and, particularly in the absence of the contracts themselves, field office personnel were inclined to see all transfers as an attempt to dump. Even though the contracts are now available at the field offices, some confusion remains as to under what circumstances a hospital can legitimately transfer patients without technically dumping.

Another part of the concern about dumping may stem from the fact that, prior to contracting and the stepped-up utilization review procedures, the field offices were not directly involved in assessing the appropriateness of transfers. Now that these offices are monitoring transfers, they better understand the issues involved. It also seems likely that, even in the absence of a systematic problem, there are some hospitals which exploit the gray area in contracts when it comes to the appropriateness of transfers.

7.2.3 Impact of Contracting on Outpatient and Physician Access

Contracting has indirect impacts on access to services other than inpatient hospitalization, particularly outpatient and physician services. The state reimbursement structure reflects the general state attitude that outpatient services are an entirely separate issue from inpatient services. Hospitals feel this misses an essential connection. Hospitals which did not receive Medi-Cal contracts were reluctant to treat Medi-Cal recipients on an outpatient basis. The reason most frequently advanced is that continuity of care suffers if the patient can not be attended on an inpatient basis by the same physician who was treating him or her on an outpatient basis.

A reason not as readily advanced by hospitals, but perhaps more significant, is that outpatient departments are usually money losers for hospitals, particularly under Medi-Cal rates. If the outpatient departments can be used as "feeders" for the inpatient side and Medi-Cal inpatient reimbursement is sufficient to make at least some contribution to fixed cost, the hospital is more willing to absorb the loss. But if the hospital does not have a contract and the outpatient department must refer inpatient admissions

to other hospitals, there is no financial reason for absorbing the loss. At least two noncontracting hospitals in our sample took steps to minimize Medi-Cal outpatient exposure after losing contracts.

The most widely publicized case of outpatient access problems was at Cedars-Sinai in Los Angeles. According to the Los Angeles Times, the hospital sent letters to Medi-Cal users of its outpatient clinics offering to help the patients find other outpatient facilities because the hospital did not get a contract. This reportedly had a severe impact on certain populations in the area who had relied on Cedars-Sinai's outpatient clinic, particularly an enclave of Russian immigrants which Cedars had been treating for several years.

Bet Tzedek, a legal agency that represents this community, gathered statements from 50 Russian immigrants on the disruption in service they had experienced. Bet Tzedek also threatened legal action against Cedars-Sinai and launched a public relations campaign against the hospital. In total Bet Tzedek received over 200 complaints from neighborhood residents, most of whom were very elderly and many of whom were partially disabled or only spoke Russian. Many of the complaints alledged that it would take over an hour each way by public transportation to get to UCLA, the hospital to which Cedars had referred most of these patients. The complaints also alleged that UCLA did not have sufficient Russian interpreters.

Although it took nine months from the time the incident first received extensive publicity, Cedars eventually worked out a subcontract with UCLA for a sufficient number of inpatient days to reinstitute outpatient services for this community and still maintain continuity of care for patients

served on an outpatient basis. It is an open issue as to whether the incident illustrates the inherent flexibility of contracting or one of the inherent problems.

In addition to potential problems with outpatient access, respondents also raised questions about the indirect effect of contracting on physician access. Several respondents indicated that contracting, and the prior approval process, were driving physicians out of the program. According to the CHA survey of medical staffs, "some physicians thought contracting was a great opportunity to get out from under Medi-Cal's billing and treatment authorization hassles, as well as its low payment schedule."[9] CMAC staff confirmed this might be a problem. According to them, several hospitals which failed to get contracts told CMAC that members of their staff simply gave up Medi-Cal practices rather than seeing Medi-Cal recipients in other hospitals. The majority of respondents addressing the issue, however, thought that many physicians were not actually dropping Medi-Cal patients, but were refusing to accept new Medi-Cal patients. Given the physician surplus in California, it is not clear this necessarily has a severe impact on recipients.

7.3 Impact of Other Changes

This study has focused on Medi-Cal's adoption of hospital contracting and has not explicitly considered other programmatic changes to the Medi-Cal program made by AB 799. At least two of these changes, however, had serious implications for inpatient hospital services: the change in the definition of medical necessity and the change in the MIA program. These two issues will be briefly examined in the following subsections.

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[9]See Attachment B.

7.3.1 Definition of Medical Necessity

AB 799 redefined which services were covered by Medi-Cal. The new definition included only those services necessary to protect life or prevent significant disability and significantly constricted the services available to Medi-Cal recipients. Previously, the definition of medical necessity was broadly defined and, according to legislative testimony presented by DHS, was delegated to negotiation between providers and Medi-Cal consultants on the basis of "community standards of practice."

According to DHS, the law mandated AB 799 restrictions on the number of services available to Medi-Cal recipients.[10] In September of 1982, DHS published a list of services which were no longer available to Medi-Cal recipients; additionally, Treatment Authorization Requests (TARs) for procedures were given additional scrutiny in light of the new standard. Many services which would previously have been authorized were denied. These included some elective surgeries which would formerly have been carried out on an inpatient basis, as well as a number of drugs and procedures which would have been provided on an outpatient basis. (Attachment C contains provider bulletins released by the state of California outlining the actual service allowances.)

The impact of this new definition on patients is unclear. On the one hand, a large number of hospital respondents told us that the change in definition was a serious annoyance, but that if a physician felt strongly enough about a particular case, he or she could appeal or resubmit the TAR several times and it would eventually get approved.

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[10] AB 799, Section 38 14133.3(a).

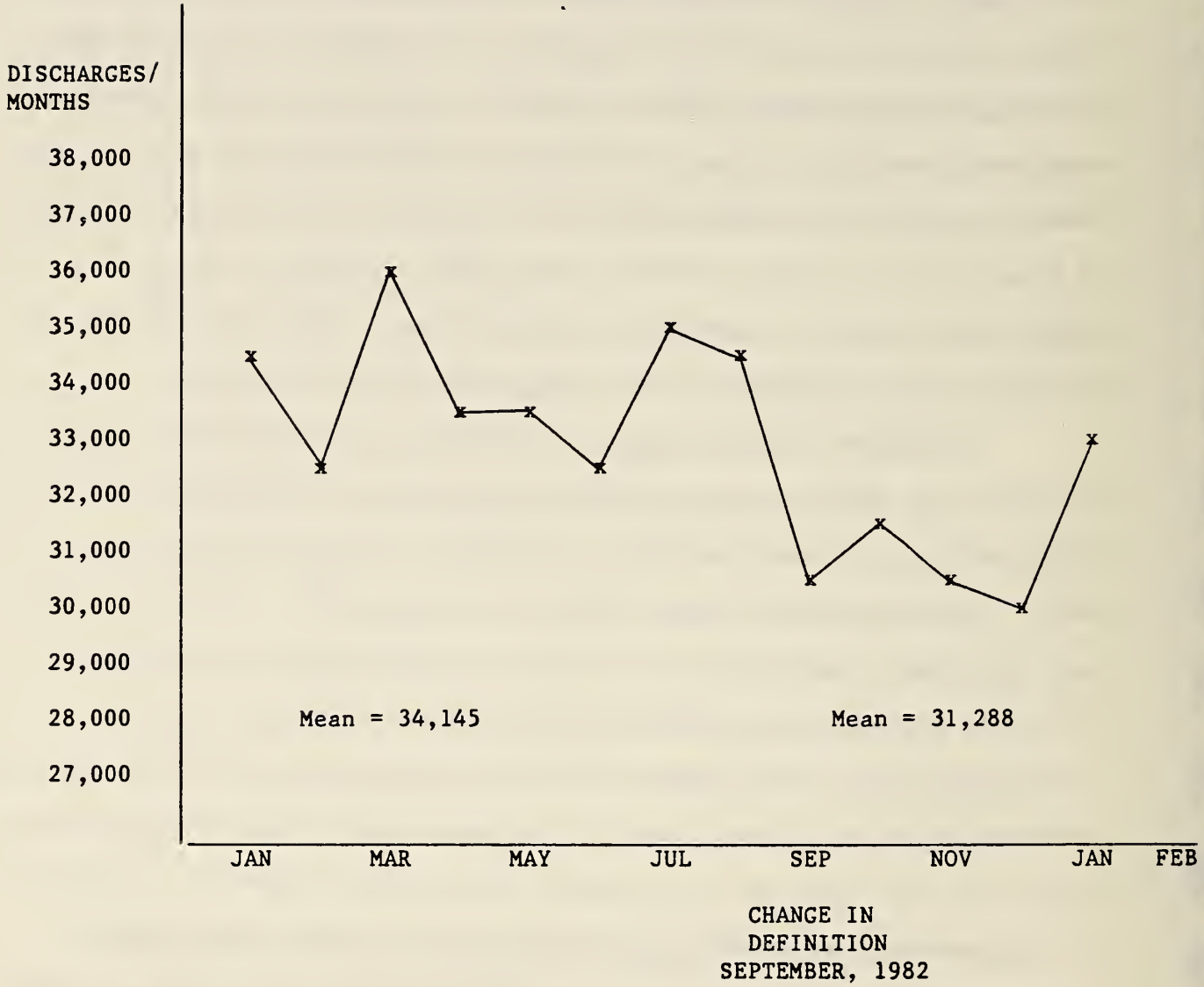
On the other hand, some respondents suggested that a significant number of recipients had been adversely affected by the new definition. Hearings were held by the Assembly Committee on Health in October, 1983 on "Prior Authorization and Medical Necessity". Testimony from physicians and consumer advocates cited a number of examples of specific problems. Many of these were traceable to the new definition of medical necessity, but some of them had nothing to do with the definition of medical necessity per se but had to do with the particular procedures used by DHS to implement the prior authorization program. Inconsistent interpretations, retroactive denials, and denials on purely procedural grounds were among the problems raised.

There can be little question, however, that implementation of the new definition coincided with a dramatic drop in hospital inpatient utilization. Exhibit 7.3 shows discharges for non-MIA and non-Medicare crossover patients by month between January, 1982 and January, 1983. Analysis of this data shows that after accounting for seasonal variations and the historical decline in admissions, the change in the definition of medical necessity corresponded with a seven percent decrease in admissions. Conceivably some of these admissions were "unnecessary" in the usual sense of the term, but it is also likely that there was a real change in the services Medi-Cal provided. It also appears, judging from testimony presented at the Assembly Health Committee hearing, that there has been a lack of uniformity in implementation around the state and, perhaps, ongoing changes as DHS reacts to criticism by relaxing some of the stricter standards. It is nevertheless likely that the new definitions significantly reduced the amount of medical services available to Medi-Cal recipients.

Our research will not address the question of whether or not these utilization reductions have caused harm to patients since our focus is on the

Exhibit 7.3

Discharges Per Month, Before and After
Implementation of New Definition of Medical Necessity[a]



[a]Discharge data from date of service claims for all non-MIA, non-Medicare crossovers. Provided by DHS.

contracting program itself. It should be clear, however, that the reduction in services was not an unforeseen consequence of contracting, but was an intended result from a deliberate, and separate, policy change.[11] As a practical matter, several legislators and other respondents were surprised at the magnitude of reductions in admissions and services and thought these reductions went beyond what was intended. Restoration of these services was adopted in the 1984 legislative session, but was vetoed by the Governor.

7.3.2 Medically Indigent Adults

The Medically Indigent Adult (MIA) program reimburses for health care provided to indigents who do not meet either income standards or categorical standards for Medicaid. In 1982 there were about 270,000 MIAs sponsored by Medi-Cal. As part of AB 799, responsibility for this program was returned to the counties. To fund these responsibilities in 1983, grants were made to each county in an amount equal to 70 percent of projected Medi-Cal expenditures on the program in that county.

It is very difficult to generalize about the effects of this change. There have been different results in different counties, counties keep data in different ways, and so on.[12] However:

- In most counties, treatment of MIAs in private facilities has been curtailed and their treatment has been centralized in county facilities; and
- Aggregate MIA hospitalization declined dramatically when this change was made.

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[11] Recall from Chapter Two that many changes were made in the Medi-Cal program simultaneously. Contracting was created by Section 17 of AB 799. The change in the definition of medical necessity was incorporated in Section 38.

[12] A bill passed in the 1984 legislative session required counties to make a uniform data submission to counties on MIA services.

The explanation for the substantial drop in MIA hospitalizations was that the MIA program had been covering not only those patients classically considered as indigent, but was also providing what amounted to catastrophic health insurance for some private hospital patients. When patients in private hospitals exhausted their insurance and other funds, the hospital would help them become eligible for MIA Medi-Cal. However, once MIA responsibilities were transferred to the counties, this category of patient stayed at the private hospital rather than transferring to the county hospital. Thus, overall inpatient MIA utilization declined, not because there were fewer eligibles but because some of the potentially eligible were reluctant to go to county hospitals.

One legislative analysis made prior to AB 799 had suggested that this category of patients accounted for about one-third of all MIA inpatient utilization. Estimates made by the California Association of Public Hospitals that, in the first year of contracting, about 64 percent of MIA patients formerly treated in private facilities were now being treated by county health systems generally support that interpretation.[13] Additionally, both CHA and Calfornia Health Facilities Commission figures show there was a large increase in the state total of uncompensated care coincident with contracting, but the data is not sufficiently detailed to show if increases in individual facilities corresponded with their previous MIA patient load.

Counties generally made out well under this new arrangement in the first year of contracting since their MIA utilization was less than

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[13] It also seems likely that some of the patients in private hospitals who were formerly classified as MIAs are eligible for Medi-Cal in a different category, primarily the disabled category. No one is even speculating as to the portion of patients who would have otherwise been MIA are now classified as some other kind of Medi-Cal patient.

predicted. As one of our more flamboyant county respondents put it: "We made out like a bandit." In light of this, however, the legislature reduced the county grants from 70 percent of the estimated 1982-1983 MIA expenditures to 61 percent for fiscal year 1983-1984. At the same time, utilization started to climb toward its previous levels and, even with a three percent increase in the grant level for fiscal year 1984-1985, county facilities were beginning to feel very strapped as their occupancies have risen to capacity. One hospital respondent indicated that private hospitals, under pressure from all payers to reduce charges, had "become more skilled in dumping patients back to the county facilities."

Consumer advocates argue strongly that access to health care has become more difficult for the MIAs. For example, it has been claimed that it takes as much as two hours to travel by public transportation to a county facility in some parts of Los Angeles County. Crowding and long queuing have also been reported at some county facilities in the outpatient areas from the beginning of the transfer, but are also now being reported in some inpatient areas as well. Some counties have charged fees to indigents or reduced services. It is also true that the amenity level at most county facilities is markedly less than at private facilities. (As the CEO of one county facility said: "Our hospital is a great place to be sick but a terrible place to recuperate.")

Whether the above problems translate into a material loss of health status for MIAs is beyond the scope of this study of contracting. The MIA program is not federally funded and is the responsibility of county governments. A preliminary study by Lurie et al., however, concluded that:

> After six months without Medi-Cal, the general health of the study [MIA] patients had worsened. In those with hypertension, diastolic blood pressure had risen to 10 mm Hg. Fewer medically indigent adults could identify a regular source of care (50 per cent after

termination versus 96 per cent before termination), fewer thought they could obtain care when needed (38 per cent versus 83 percent), and fewer were satisfied with their care (60 percent versus 91 per cent). The [regular Medi-Cal] group, not affected by the legislation, had no significant change in any of the above measures.[14]

[14]Nicole Lurie, Nancy Ward, Martin Shapiro and Robert Brooks "Termination from Medi-Cal - Does It Affect Health", New England Journal of Medicine, August 16, 1984.

CHAPTER 8:

IMPACT ON OTHER PAYERS

There are two general issues concerning the impact of hospital contracting on other payers: changes in the share of hospital financing shifted to other payers and the indirect effects of Medi-Cal contracting on hospital and payer attitudes.

8.1 Medi-Cal Hospital Contracting and the "Charge Shift"

The majority of the analysis on this issue will be undertaken as part of subsequent qualitative analysis when more comprehensive data is available. At that time, it will be possible to analyze changes in hospital charges and compare them to changes in Medi-Cal reimbursement. Such an analysis will reflect the degree to which Medi-Cal "savings" were shifted to other payers. In the interim, it is necessary to rely on perceptions of insurance companies and some aggregate data.

When AB 799 was passed, it was packaged with AB 3480 which gave private insurers the right to also contract with hospitals. Part of the rationale for the passage of AB 3480 was that the ability of private payers to contract gave them the ability to protect themselves from hospital attempts to recover lost Medi-Cal revenues. There was a certain amount of disingenuity in that argument since private payer contracting surely could not have been developed and marketed as quickly as the Medi-Cal contracting program could be implemented. Consequently, even under the best of circumstances, there was a high probability of shifts to private payers in the first year of contracting, and possibly for several more years as well.

All respondents representing insurance interests felt that it was too early to tell how much they had been victimized by charge shifting as a

result of the Medi-Cal program. Although Medi-Cal contracting had been operational for about a year, respondents felt it would require at least two years for the impact of contracting on their rates to work its way through the system.[1] Respondents suspected that part of the Medi-Cal savings would show up as higher charges to private payers, but on balance they were much more concerned about hospital responses to the Medicare Prospective Payment System.

Conversely, one legislator suggested that while he indeed expected some charge shifting, he felt that Medi-Cal contracting might also lead to some general economies of hospital operation in which private payers would benefit. While this is a question to be primarily addressed by subsequent quantitative analysis, available aggregate data suggests that California hospital cost growth has moderated more than the rest of the nation, but trends in charges are less clear.

Exhibit 8.1 compares California aggregate hospital cost and revenue information (from the California Health Facilities Commission) with national data (from the AHA hospital survey panel data) for the years 1981, 1982 and 1983. The first three lines compare changes in hospital expenses. For both inpatient and total expenses, California was growing more slowly than the rest of the nation between 1981 and 1982. However, the gap between California and the national totals (which include California) grew signficantly between 1982 and 1983, the effective year of contracting. With regard to inpatient revenue per case, the change is even more dramatic. 1981-1982 California growth is greater than the national rate, but between 1982 and 1983, the California expense per inpatient case growth rate is significantly under the national

[1] In part this is because of the long lag between delivery of a health care service and complete processing of claims for that service. In part, this is because changes in hospital charges are not generally made continuously, but happen at given points in the hospitals' fiscal years.

Exhibit 8.1

Changes in Hospital Revenues and Expenses,
California and the Nation, 1981 to 1983

	1981-1982	1982-1983
Total Expenses		
California	12.8%	6.6%
National	15.8%	10.2%
Inpatient Expenses		
California	13.4%	6.7%
National	15.6%	9.6%
Inpatient Expense Per Case		
California	16.2%	8.3%
National	15.5%	10.2%
Net Inpatient Revenue Per Case		
California	16.9%	8.9%
National	16.2%	10.4%
Gross Inpatient Revenue Per Case		
California	21.7%	13.2%
National	NA	NA

Sources:

California: California Health Facilities Commission, Quarterly Financial and Utilization Report, 4th Quarter, Year-to-Date, 1981-1983. (All hospitals, excluding Kaiser, Shriner and dental hospitals, including physician expenditures.)

National: AHA, Survey Panel Data, 1981-1983.

rate. This data reflects only two years, is completely aggregated, and makes no attempt to account for a large number of other factors which might have influenced the outcome. Yet the magnitude of the change is compelling and very strongly suggests that something happened in California which caused hospital expenditures to increase at a slower rate than nationwide.

The next two lines of Exhibit 8.1 show net and gross inpatient revenue per case increases. Gross revenue is the total amount of charges assessed against patients, regardless of whether or not those charges were paid. Net revenues are the amount remaining after uncompensated care (care for which no one paid) or contractual allowances (discounts from charges allowed to certain payers, such as Medicaid, Medicare or PPO contractors) have been subtracted from gross revenues. The growth pattern of net revenue mirrors the trends in inpatient per case expense. Gross revenues, however, are much more interesting in determining the impact of contracting on other payers since gross revenues are a much more accurate indicator of the increases faced by charge payers. (In California, most commercial insurers pay charges, as does Blue Cross in the portion of the state covered by the old Northern California Blue Cross.) For California, gross revenues per case jumped considerably above either net revenue or expenditures. Without more detailed data, it is impossible to determine the degree to which this increase is a result of more uncompensated care or greater contractual allowances.[2] It

[2]Analysis of the relationship between deductions from revenue and gross charges is difficult because simply increasing charges increases deductions from revenue even if there are no other changes. However, it is possible to determine from the CHFC data that deductions from revenue in "real" terms are increasing. Between 1981 and 1982, an increase of $1.58 in gross revenues per California case was required to generate a $1 increase in gross revenues; between 1982 and 1983, $1.90 was required to generate a $1 increase in net revenues. Thus, deductions from revenue are increasing faster than would be the case if they were being driven only by increases in gross revenue.

is virtually certain, however, that some of this increase is in Medi-Cal contractual allowances since Medi-Cal rates were actually reduced during this period.

Unfortunately, there is no appropriate source of data for increases in gross revenue nationally, so it is impossible to determine whether or not the apparent savings relative to the national trend in expenditures were reflected in charges. There is ample reason to believe that deductions from revenue increased in the rest of the nation also. Moreover, since gross charges are a function of expenditures as well as deductions from revenue, it is possible that the relative California decrease in expenditures more than offset any increases in deduction from revenue. If that were the case, it would be possible to suggest that the overall impact of contracting on private payers was beneficial <u>despite</u> increased cost shifting. This questions will be addressed in much more detail in subsequent reports.

8.2 Indirect Effects of Contracting

Discussions in California--with hospitals and payers alike--stressed the fact that as important as the specific changes in Medi-Cal were, the indirect changes were more important to other payers. This connection is evident from the very beginning of Medi-Cal contracting when AB 3480, specifying the ability of private payers to contract, was specifically joined with AB 799 for purposes of legislative procedure.

A few respondents went so far as to suggest that Medi-Cal hospital contracting could not have been enacted without the balancing provisions for private payers of AB 3480. But most respondents felt that the budget crisis was so severe AB 799 would have passed with or without AB 3480. These respondents, rather, felt that AB 799 provided private payers an opportunity

to obtain the direct contracting language they had wanted for some time but, due to intensive opposition from the medical lobbies, would not have been able to get through the legislature were it not tied to the Medi-Cal budget crisis. Several respondents suggested that fairly early in the process key legislative players had seen the opportunity to pass both bills at once and that the entire package was more or less intended from the beginning.

Many respondents saw the combination of the two provisions as an approach to hospital cost containment which is an alternative to a system of direct state regulation. This combination addresses Medi-Cal costs, gives private payers additional leverage to address their own costs, and sends the message to all payers that they will have to control their own costs. How it will compare to direct rate regulation in terms of both magnitude and distribution of cost increases is unclear. Likewise, the potential impact on patients between rate regulation and the California approach is unclear. What is clear, however, is that evaluation of the 1982 reforms in California should recognize that the combination of provisions can be considered an alternative to direct rate regulation. Over the long run at least some attention should be given to this aspect of the system rather than focusing exclusively on the Medi-Cal portion. Failure to do so would be to miss an important aspect of what is being tried in California.

Most respondents felt that the relationship between Medi-Cal contracting and private pay contracting went beyond the legislative relationship, but indicated that the Medi-Cal changes had been instrumental in creating a whole new mentality among both payers and hospitals. As one hospital administrator said:

> All of this contracting business has little to do with Medi-Cal. The biggest impact is the mind sets of the private insurers. All the forces were ready, but they needed a catalyst. For years the medical community stonewalled, but once somebody pushed that button,

> it all blew up. This law broke the back of the medical community. I am now sitting on fifteen contracts. Most of them exist only on paper, but they do exist. This change buried cost based reimbursement.

In understanding exactly how much the Medi-Cal changes could be viewed as catalytic, it should be understood that the California Insurance Department had been approving group policies which undertook such direct contracting since 1972. In other words, AB 3480 was not strictly necessary for contracting to have gone forward. To be sure, the statutory basis of the Insurance Department for so approving plans was not unambiguous and insurance companies felt the threat of litigation was sufficiently strong to disuade them from entering into contracting procedures. But more intrepid insurers had previously had such policies approved. In a very real sense, the barriers to contracting had been more conceptual than legal. The combination of AB 799 and AB 3480 was probably more important for its contribution to surmounting these conceptual obstacles than its legal changes.

One important contribution was that Medi-Cal contracting proved contracting was possible. While there are many reasons why no other payer is comparable to Medi-Cal, payers were impressed by Medi-Cal's ability to, first, get contracting done in about six months; and, second, get substantially lower rates. This latter can not be overemphasized. Medi-Cal was historically the worst major payor in California. For years hospitals had been complaining about the low rate of payment and the administrative problems. But when the crunch came, most hospitals were willing to take substantial rate cuts to stay in the program. In a GOSHN brief during the litigation with St. Mary's of San Francisco, GOSHN claimed that St. Mary's offered William Guy a contract with the dollar amount blank and said if he would sign, he could write in whatever rate he wanted. Suddenly hospital assertions about what they could or could not do to control costs and rates looked like years of crying wolf.

Nor was this lesson lost on buyers of private insurance. Much interest in cost containment had been expressed by various consumer groups during the legislative session which passed AB 799 and AB 3480. These groups were aware of the enactment of both provisions and consequently knew that the insurance companies now had a new tool to control costs. Had Medi-Cal failed in the contracting experiment, it would most likely have led to a lowering of consumer expectations and certainly slowed the rush of insurance companies to contracting.

Medi-Cal contracting also contributed to the ability of private payers to contract by orienting hospital mind sets toward contracting. It accomplished this directly, by forcing virtually every hospital in the state to consider what contracting meant and by creating a situation in which most actually submitted bids on contracts. Both hospital respondents and insurers indicated that the Medi-Cal contracting experience was extremely educational. As one hospital administrator said:

> You can talk about marginal cost until you are blue in the face, but you don't understand what this really means until you face the loss of a major payer. Once we realized that...you better believe we sharpened our pencils. And it wasn't just for Medi-Cal. It was for Blue Cross and for any other contract we can get.

Working through the Medi-Cal contract also caused hospitals to reassess basic parts of their operation, including the competence of their financial personnel, the adequacy of their information systems and their current knowledge about costs and patients. And in the course of forcing hospitals to directly contend with contracts, hospital lawyers and accountants were exposed to contracting and the issues involved therein. Again, both hospital and insurer respondents indicated this made other contracting much easier.

Whatever the potential of contracting, however, it is necessary to keep in mind that this potential has not yet been achieved and there is no

guarantee that it will be achieved, however strong the likelihood. Even two years after the passage of AB 3480, in August, 1984, most respondents indicated that very few hospital services were actually being provided under preferred provider contracts. Blue Cross, whose Prudent Buyer program is the most widely advertised private contracting effort, had about 300,00 enrollees in the program in September, about 200,000 of whom had come from conversion of individual contracts in areas where they felt their network was adequate. Blue Cross was, however, hoping that they would have 800,000 enrollees by the end of 1984 because of upcoming major open-enrollment periods.

Ultimately, PPOs will prove a fad if consumers are not willing to buy insurance policies based on PPOs. Many factors will go into determining whether or not such policies are a market success. For instance, premiums under the least expensive Blue Cross Prudent Buyer Plan are about equal to premiums for Kaiser HMOs. Yet this variant of the Prudent Buyer Plan requires significant co-pays. Hence, the Prudent Buyer Plan is mid-way in cost and freedom of choice between conventional fee-for-service and an HMO. But at this point it is uncertain as to whether a market exists for such a package of services. The logic is powerful, but market responses are not always logical. It could be, for instance, that once consumers reach a point that they are willing to give up freedom of choice, that subsequent choices are made purely on economic factors. In which case, the Prudent Buyer Plan might not fare well since it is still more expensive than Kaiser.

Likewise, the cost saving potential of PPOs is not yet demonstrated. For instance, critics of some PPOs have said while they have achieved significant discounts in rates, the hospitals with which they have contracted were such high cost hospitals to begin with that there will be no net savings. Other analysts have warned that some of the features used to

entice potential enrollees, such as waiver of copayments, may more than offset any savings obtained from utilization of less expensive providers. One respondent pointed out that while there are a number of cost containment options potentially available to PPOs, most marketing PPOs are using only a small fraction of them. If early PPOs do not show cost savings, there is no guarantee that payers will move on to other PPO features, but might turn to rate setting or other approaches.

Thus, the jury is still out on the ultimate importance of PPOs. Medi-Cal contracting has created a climate in which PPOs are possible. Whether or not they will flourish remains to be seen. In the meantime, observers should neither overestimate the realities nor underestimate the potential.

CHAPTER 9:

IMPACT ON HOSPITALS

The most tangible impact on hospitals will result from revenue reductions as a results of Medi-Cal contracting. Actual analysis of revenue reductions and the impact therefrom will not be carried out until the second report. This section will provide an interim report based on hospital perceptions of the results of contracting, including the impact on hospital organization, particularly relationships with physicians.

9.1 Hospital Steps to Control Costs

Quotes from hospital administrators at the end of the previous chapter illustrate what hospital respondents told us: Medi-Cal contracting is the harbinger of a different game. This attitude does not spring from Medi-Cal contracting alone. The attitude is a product of Medi-Cal contracting, discussion of private payer contracting, Medicare DRGs, warnings about the solvency of the Medicare Trust Fund, and the undeniable social consensus that health care has become too expensive.

Generally speaking, the new attitude of hospital administrators is that the time when a hospital could grow by simply maximizing revenue is over. To survive in the future, hospital respondents suggested, efficient management on both sides of the ledger would be necessary. As one hospital respondent put it:

> Up until now this has been a fairyland. You charge more and you get more. We became very good at increasing charges. Now we will find out if we can manage these institutions.

Whether or not hospital administrators actually believed what they were telling us about the need to change their method of business, or whether

or not they will actually be able to accomplish those changes, are empirical questions which will require time to answer. In the meantime, however, hospital respondents certainly spoke as if they were concerned about cost control. All hospitals in our sample claimed to have taken steps to reduce costs since the onset of Medi-Cal contracting.[1] Hospitals spoke of their steps in three general areas: staffing costs, general budgeting and practice patterns.

More than three-fourths of the hospitals in our sample indicated some effort at reducing staffing costs in the last year. Most respondent hospitals claimed to have "increased productivity" during the previous year. The most commonly reported strategy was reduced use of overtime and registery nurses. About one-third of the hospital respondents reported laying off staff or using attrition to reduce the total number of positions. The extent of staff reductions varied from substantial (two hospitals which claimed to have reduced staff by 15 percent) to insignificant (a hospital which reported a reduction of less than 1 per cent.) Three hospitals said they had put more of their nurses on an "as-needed-basis" with the result that these nurses would not work unless patient census exceeded predetermined levels. It must be remembered, however, that most of hospitals were experiencing some volume reductions at the same time, so staffing reductions do not necessarily reflect reduced expenditures per admission.

Most hospital respondents claimed that staffing reductions were targeted at non-patient care areas as much as possible. But, as is evident from the above, there were some absolute reductions in nursing hours as well as other hours. It will require more detailed analysis to determine the

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[1]Of course, there have been other important changes in health care financing since the beginning of contracting--including the Medicare PPS.

relative change taking into account volume declines. Hospitals also reported attempting to hold down staffing costs by reducing fringe benefits (two hospitals, for instance, reported eliminating shift differentials) or foregoing wage increases (a strategy used by two hospitals and being discussed by others).

These findings correspond closely with a CHA survey of hospital work force which found that, of 245 responding hospitals, three-fourths had cut back working hours, implemented hiring freezes, layoffs and reductions in force or closed service units.[2] Sixty-eight of the 245 responding hospitals had permanently laid off 1545 FTEs and another 63 hospitals had experienced temporary layoffs. Exhibit 9.1 shows the composition of permanent and temporary layoffs reported from the 245 responding hospitals. AAI estimates from this data that between 1982 and 1983 full-time hospital RNs decreased by 8.7 percent and part-time RNs by 36.7 percent, although when part-time reductions were measured on an FTE basis, the reduction was only 20.4 percent.

In addition to wage contraction, hospitals mentioned several other steps being undertaken to control costs, such as "quality circles" to reduce supply waste; greater standardization of supplies among physicians, pacemakers in one case; closer review, or in one case virtual elimination, of movable equipment expenditures; energy conservation; and "crack-downs" on weekend admissions. Also, although it is not a specific step, most hospitals reported that budgeting procedures were generally "tighter", a sentiment often echoed by Directors of Nursing who reported that they had seen much greater concern about budget issues in the last two years than previously.

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[2]Charles H. White and Cindy Arstein-Kerslake, "The Shrinking Hospital Workforce," CHA Insight, August 23, 1984. This followed a 1982 survey which showed layoffs of 2136 FTEs in 117 of 268 responding hospitals and the elimination of another 3070 FTEs through attrition and hiring freezes.

Exhibit 9.1

California Hospital Work Force Reductions, 1983

Personnel Category	Number of Hospitals	FTE Positions Affected by Temporary Reductions	Number of Hospitals	FTE Positions Affected by Permanent Reductions
Management and Supervision	12	41	25	64
Staff RN	29	385	28	307
Staff LVN	23	144	27	139
Aides and Orderlies	31	352	33	262
Respiratory	12	18	8	15
Physical Therapist	4	4	4	6
Medical Technologist	11	41	15	23
Medical Record Technician	6	10	3	3
Other Technicians and Specialists	15	52	30	97
Environmental and Food Services	20	91	28	147
Clerical and Other Administrative	25	144	38	167
Physicians (Salaried)	3	9	2	8
Non-Physician Medical Practitioner	0	0	2	4
Other	20	159	21	78
Total	63	1,234	68	1,545

Source: CHA Survey, 245 responding hospitals.

Additionally, every hospital had some plan to increase monitoring of physician behavior with the onset of DRGs. It was clear, however, that hospitals were moving at different speeds and with different levels of sophistication. Some already had software in place and were beginning serious analysis; others were still talking about it. Some hospitals had developed protocols for major DRGs; others were still forming committees. Some had established educational sessions for physicians, nurses and other staff; others were still contemplating such sessions. Part, but not all of the differences, were related to the DRG implementation date.

It was also clear that there were major differences in the latitude which hospital respondents felt they would have in dealing with physician behavior. Some seemed confident that they would be able to change phyician behavior, one way or the other. One hospital indicated that its by-laws now allowed physician interactions with the utilization review committee to become part of the physician's file and would be considered in renewal of staff privileges. But the response of a small community hospital was more typical:

> We are getting some software and this will help us identify the abusers. We pretty well know who they are, but this will document it. We have tried before to deal with the abusers but in the end we are fairly lenient because we don't really have any control. If we identify an overutilizer and we lean on him, he'll go somewhere else and take his patients with him and we are even worse off.

In addition to general profiling of physician practice patterns, several hospitals were putting more effort into specifically managing physician ancillary use. Three hospitals had worked out programs with their pharmacist to more carefully monitor prescriptions and to work with physicians to improve their ordering practices. One of these hospitals had hired a pharmacologist consultant for this; the other two used existing staff. One of the latter had started the pharmacist monitoring Medi-Cal patients because

they were on a fixed per diem. As the hospital went onto DRG, the pharmacist would start monitoring Medicare also. The small hospital whose CEO is quoted above was hiring a full-time medical director in hopes of exercising better control over physicians.

There were changes in practice patterns that applied to nursing also--although perhaps these should really be considered reductions in staffing costs. Two hospitals, for instance, had recently eliminated special IV teams. Another hospital had changed the operating procedure for the respiratory therapy team so that the therapist no longer stayed with the patient during the time the patient was receiving Intermittent Positive Pressure Breathing treatment.

It is not possible to determine which, if any, of the above steps will have a material effect on costs. Many of the specifics are suspiciously reminiscent of "Voluntary Effort" steps which produced a momentary pause in the rate of hospital inflation, followed by a return to the old rate as soon as the threat of a national hospital cost containment program faded. One big difference, however, is that the Medicare PPS system will not be going away. That system, and the resulting information which it will generate about practice patterns, is likely to lead to long term changes.

Moreover, there have been clear changes in incentive structures which are likely to produce lasting results. Two of the hospitals in our sample which appeared to have made significant cost reductions in the previous year, for instance, felt the advent of contracting and PPS was helping them enjoy very good fiscal years. Both these hospitals indicated that for the first time reductions in operating cost did not lead directly to reductions in revenue--as they would have under the previous cost-based Medi-Cal and Medicare systems.

9.2 Hospital-Physician Relationships

The above section on changes in practice patterns touched on one of the constant themes of our hospital respondents: the Medi-Cal program, like the DRG program, considerably increases tension between hospitals and physicians. Both the Medi-Cal program and the DRG program penalize hospitals if physicians overutilize services, but have no corresponding penalties for physicians. Physicans, as several respondents pointed out, get paid for Medi-Cal services provided to inpatient recipients on days for which the hospital has been denied for Medi-Cal reimbursement.

Consequently, one of the most often raised shortcomings of the contracting (and utilization review) program was the failure to offer congruent incentives to hospitals and physicians. Many hospitals would prefer a capitation program, although there was also wide spread skepticism on how the state would work out the details of such a program.

This is a position shared by many state officials. As one put it to us: "What we would really like is a greed incentive system: where doctors can make money by keeping patients out of hospitals." Physician spokesmen were less enthusiastic about that approach, cautioning that if both the hospital and the physician could benefit from what might devolve into "excessive zeal" the patient would be at serious risk.

In the interim, hospital administrators feel they are being placed in a very difficult situation trying to ride herd on physicians who have little incentive to control costs. As one respondent put it:

> Education without incentives gives you a little.
> But education with incentives could give you a great deal.

None of the hospitals in our sample had, in fact, developed incentive programs for attending physicians. However two hospitals had recently rewritten the contracts of hospital-based physicians so that they would be reimbursed on a per case basis rather than on a revenue related basis. It was believed this would create incentives to moderate ancillary utilization. Another hospital had included as part of their bid to the Blue Cross Prudent Buyer Plan a risk pool by which physicians would have some direct incentive to control utilization. (The administrator of that hospital thought, however, that was one of the reasons they did not get a Blue Cross contract: "Blue Cross was not prepared to handle anything that complicated.")

There are two other physician-related issues, open staff privileges and the overall impact of contracting on physician admitting practices, which also bear consideration.

Open staffing was required as part of AB 799 for any hospital receiving a Medi-Cal contract. In the initial discussions of contracting, this was seen as a possible impediment to hospital willingness to contract. In point of fact, it was not a major issue, except perhaps at a few teaching hospitals. Many hospitals already had open staff privileges. Under contracting, hospitals were still able to review requests by physicians for staff privileges and could refuse privileges for cause. Apparently the ability of hospitals to refuse for cause at first created friction because some physicians felt any attempt to review credentials was a violation of the contract requirements. But according to respondents in hospitals and the state, even these issues have disappeared as participants better understand the rules of the game. At least one hospital in our sample made some

adjustments in its bylaws in anticipation of contracting to make sure that its standards for denying privileges were sufficiently clear that they could withstand scrutiny.

Most contracting hospitals in our sample had experienced some requests for staff privileges which they felt were attributable to contracting--i.e. from physicians with large Medi-Cal practices at noncontracting hospitals. On balance, contracting hospitals were ambivalent about the results. Most felt that the new physicians brought some additional Medi-Cal patients, but not many private pay patients. Only one hospital respondent expressed a positive strategy to develop this resource:

> We have tried to woo a few specific internists from _____ hospital which did not contract. We made it clear to them that we would like to see them bring their Medi-Cal patients here but we've made some hints, some subtle, some not so subtle, that we don't want to see Medi-Cal only. We haven't seen a lot of results but we think we are beginning to see the tiniest trickle. This will take a great deal of time.

He also pointed out that while both these hospitals had won Blue Cross contracts, there were other contracts which only his hospital had won. He felt this was important because physician patterns could not be easily changed by only one payer but were influenced by a pattern of payers. (Other respondents, however, had suggested that one payer could in fact shift practice patterns over time because of the reluctance of physicians to let their practices get spread over more than one hospital.)

On balance, it does not seem that contracting caused any major shifts in the patterns of physician admitting practices in the short run, but most hospitals are watching them closely for longer-run trends.

9.3 Noncontracting Hospitals

Our sample included five noncontracting hospitals. It is even more difficult to generalize about these hospitals than about the contracting hospitals given the small sample size and the significant differences among these hospitals to begin with.

Three of the five noncontracting hospitals are rather small proprietary hospitals which had relatively heavy Medi-Cal occupancy (28, 23 and 20 percent respectively) prior to contracting. All three were operating at middle capacity (51, 57 and 64 percent respectively) prior to contracting. Immediately after contracting their censuses dropped by between a third and a half. One has seen its occupancy stabilize at about half the previous rate; one has increased somewhat since and another has slid further. In all three cases, the loss of census was greater than the number of Medi-Cal patients lost. All three hospitals also lost extensively among their Medicare and private payers because physicians either wanted to consolidate practices or were under pressure from those hospitals to which they brought their Medi-Cal to bring some better payers. (One hospital claimed that other hospitals in its area had informal policies that for every three Medi-Cal patients, the physician was expected to bring in one private pay patient.)

All three hospitals have experienced major reductions in staff and services. (One, for instance, phased out its maternity unit which further contributed to the loss of private payers.) One of these hospitals is currently operating at 20% capacity; the hospital does not believe it can stay open long under these circumstances and is looking for a buyer. A second one, which belongs to a chain, was on the market, but has been removed from the market and management believes there is some chance it can be salvaged,

particularly if it gets a Medi-Cal contract in the near future. Two of the three have experienced a significant increase in uncompensated care.

It is very hard to know, however, how typical these hospitals are of noncontracting hospitals or even of small noncontracting hospitals. All three had special circumstances and at least two of the three had substantial problems prior to not receiving contracts. Perhaps their failure to have contracts, even though all three are located in relatively high density Medi-Cal areas, is as much symptom as cause of their problems.

A fourth noncontracting hospital is a large teaching hospital with more external resources. It is reporting some financial stress as a result of its failure to win a contract and is having difficulty with its teaching programs. On the other hand, the lack of contract has not threatened the existence of the hospital, and the hospital is not actively seeking a Medi-Cal contract. It is hoping to subcontract with another teaching hospital and increase its HMO contracts to regain part of its losses. This hospital has not experienced any appreciable loss in private pay patients and is reasonably healthy from that perspective. Nor has the hospital been forced to make drastic cuts in its service package. The experience of this hospital is not appreciably different from the experience of the large San Francisco hospitals which did not get contracts (although those hospitals were only out of the Medi-Cal program for several months).

The fifth noncontracting hospital is somewhat between the two extremes outlined above. It is a middle size hospital which enjoyed good occupancy before contracting and at the time of the site visit was running about 70 percent occupancy, despite the loss of Medi-Cal which constituted

about 15 percent of its previous occupancy. It has, however, experienced loss of some physicians and, as a result, some patients who had been using the hospital for years.

At the time of the site visit, four of the five noncontracting hospitals were seeking Medi-Cal contracts and saw them as a way of improving their fiscal condition. Two of the four have since signed contracts with Medi-Cal.

Interestingly, there was some sentiment among medical and nursing staffs that not having a contract was not so bad. In two of these hospitals the director of nursing volunteered that nursing morale had improved dramatically and that nursing turnover had decreased substantially.[3] A third hospital said the lack of contracting had been a good excuse to get rid of "low quality" physicians--all of whom had substantial Medi-Cal loads. Staff of a fourth hospital was pleased that the hospital would not have to open up its staff. One administrator made the point that the majority of physicians who were substantial Medi-Cal admitters were young physicians and not part of the hospital's physician leadership. The older physicians, she indicated, had already pruned their Medi-Cal admissions and were not as concerned about contracting.

A final note on noncontracting hospitals is that in four of the five hospitals we visited, major players from the contracting period were no longer employed by the hospital. It is impossible to determine if this was coincidence or the beginning of a trend.

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[3]The two hospitals in which the director of nursing felt morale had improved were the two hospitals which did not sign contracts.

CHAPTER 10

CONTRACTING AS AN ONGOING PROCESS: THE SECOND YEAR

AB 799 called for the replacement of GOSHN with the seven-member California Medical Assistance Commission (CMAC) on July 1, 1983. By that time, all but a few significant HFPAs had been closed. Contracting was up and running. William Guy fulfilled his promise to stay only one year and subsequently retired to Maryland. The first phase of contracting was concluded.

This chapter addresses the second phase, the evolution of contracting into an ongoing process. Not surprisingly, the problems and solutions of a stabilized and ongoing process are somewhat different from those required for the rapid implementation of contracting. The first section of this chapter will describe the second round of contracting. The next section will consider the institutional adaptations made after CMAC replaced GOSHN. The final section will address issues that affect the future of contracting.

10.1 The Second Round of Contracts

Every contracting hospital in our sample hoped to increase its rate when contracts were reviewed in the spring of 1984, one year after contracting began.[1] Hospital respondents believed that the low rates negotiated in the first year were a function of the state's budget crisis and that some relief would be afforded in the second year since the state's fiscal position had improved. DHS staff, on the other hand, generally believed that rates could be rolled back even further since GOSHN had contracted with such a large percentage of hospitals. A typical sentiment expressed by DHS staff was: "It's obvious that you are paying too much if you have contracted with hospi-

[1]Most contracts had provisions which called for an annual rate review.

tals capable of providing 200% of the needed capacity." However, at the time of our site visit in January 1984, it was not clear which direction CMAC would take in the second round of negotiations.

As it turned out, CMAC followed neither approach. Instead, CMAC adopted a policy of no net increase in rates during the second year of contracting. At the time of this writing (early September, 1984) CMAC had been able to maintain this policy. Prior to September, there were few attempts to roll rates back, and likewise, few rate increases. Thus, CMAC kept inflation to zero for the costs of contracting hospitals. Given the way California measures savings--outlays under contracting as compared to what would have been made under the old system--simply holding the rates constant increases "savings" by the amount of inflation in the hospital market basket during 1983.

Over a quarter of the contracting hospitals sought rate increases during the spring of 1984.[2] Through July 1, CMAC had changed rates for only 11 hospitals. Although CMAC staff were unable to provide specific numbers, we believe the rate changes were evenly split between increases and decreases. CMAC staff suspected that they would give more increases to some hospitals with which they had not yet settled. They felt the entire process would be settled by late October or November.

To this point, there have been only two terminations as a result of

[2]It is very difficult to get exact counts on hospital requests for rate changes. First, many hospitals which fully intended to seek rate increases were dissuaded by CMAC's announced no net increase policy and initial contacts with CMAC staff. This accounts for the relatively low number of requests (64 through June 30, 1984). Second, a number of hospitals sought (and some obtained) small back-door rate increases through changes in hospital-based physician reimbursement policies. (26 of 33 requests were approved; we do not know how many of these were in fact rate increases. In most cases, however, we assume any rate increases granted through this route were very small.) Finally, as suggested above, CMAC staff is rather closed mouth about precisely what they have done in order to avoid tipping their hand to other hospitals.

CMAC's general refusal to increase rates. Thus, a total of four hospitals terminated in the first year of the program: two in the first six months and two during this second round of rate negotiations. One of the terminating hospitals was Merritt-Peralta in Oakland. This hospital served a large number of Medi-Cal recipients, but CMAC was able to replace it with Providence Hospital which is virtually across the street and was not awarded a contract in the first year.

The other termination was the Tri-City Hospital District near San Diego. The Tri-City District, which actually runs two hospitals, provided more than 90% of the Medi-Cal care in its HFPA. CMAC contends that the Tri-City termination does not pose severe access problems since there is a hospital in a neighboring HFPA which is about twenty-five minutes away. CMAC is hopeful that it will be able to renegotiate with the Tri-City Hospital District in the near future.

Consumer advocates in nearby San Diego concede that the neighboring hospital is within the thirty minute travel time standard established by GOSHN by automobile, but they question whether other hospitals are within that travel time standard by public transportation. The consumer advocates also contend that a severe access problem is developing because physicians who practice at Tri-City, particularly OBs, are refusing to accept Medi-Cal patients.[3] Thus, patients have to find new doctors in another HFPA. Consumer advocates recommend that CMAC declare the HFPA "open" unless some accommodation can be reached to bring Tri-City back into the contracting program.

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[3]In fact, at least one respondent suggested the problem was caused because physicians wanted to dump their Medi-Cal practices.

Both state and consumer respondents felt that Tri-City was an unusual case. Among other things, its occupancy was above 95% which meant that it could more afford to lose Medi-Cal than a hospital with lower occupancy. Moreover, both CMAC and consumer advocates felt that Tri-City had taken an unusually tough line during negotiations because of its advantageous bargaining situation. Respondents were of the opinion that the Merritt-Peralta situation was more typical; because of low and declining volumes from other payers CMAC could easily find beds for Medi-Cal recipients if a particular hospital was unwilling to meet CMAC's terms.

Hospital respondents were typically more caustic in their responses during the second round of negotiations than during the first. Virtually every hospital with whom we followed up expressed some bitterness at the lack of meaningful negotiation and at the fact that noncontracting hospitals received rate increases in the vicinity of 10 per cent.[4] There were also complaints of bad faith which were conspicuously absent in hospital characterizations of the first round, except for a few isolated incidents in San Francisco.

The hospitals with which CMAC has not yet settled as of September were those which present CMAC with their most difficult problems, particularly the Los Angeles County (LAC) hospitals and the state university hospitals. According to LAC officials, the LAC hospitals account for more than 40 per

[4]Noncontracting hospitals--those in areas not covered by contracting or offering emergency services within areas covered by contracting--are under the basic California state plan which calls for cost reimbursement up to limits set by the rate of increase in inflation from a base year of 1981 and the 60th percentile of their peer group. It must be remembered that about half the state's hospitals are reimbursed on this system, even though they account for less than one-quarter of the Medi-Cal patient load. In contracting areas, emergency use at non-contract hospitals accounts for about 14 per cent of all area use.

cent of all the contract days in Los Angeles County, and almost 20 percent of all contracting days. As discussed in Chapter Four, contracting in Los Angeles is hard to imagine without the LAC hospitals; likewise, it is hard to imagine LAC being able to survive without its Medi-Cal revenue.

There is also a substantial political element to the LAC settlement. In the spring of 1984 the legislature increased the block grant to county hospitals for care of MIAs by three percent and other subsidies by an average of four percent. If the legislature was willing to make such increases with 100 percent state money, there may be some political support for increased Medi-Cal rates which are 50 percent matched by the federal government. If CMAC does try to hold the line with LAC, there will be the strong temptation for LAC to start a political battle.[5] The same can also be said of the University of California hospitals.

To some extent it is surprising that the state did not use the Medi-Cal rate, and its accompanying federal match, to avoid the need for increasing grants made with 100 per cent state money. Apparently the state's reasoning is to avoid setting a precedent which would increase pressures for increases to all hospitals, a position which might have been more expensive than the foregone federal match.

In addition to holding rates constant, CMAC has consistently tried to sign up new hospitals and to close additional areas. CMAC has contracted with an additional 15 hospitals during the first six months of 1984, about half of them in HFPAs which had previously been closed. Expanding the number of hospitals under contracting has proved a more important source of savings

[5]There is considerable political pressure with regard to the LAC contract and legislators are attempting to get involved in the outcome. At least to this point, however, it appears that CMAC commissioners have avoided any direct political involvement in the negotiation.

than redirecting patients to lower cost hospitals. For all intents and purposes, there has been no attempt to redirect patients toward lower cost hospitals.

10.2 Organizational Adaptations

The previous section described the results of the second round of contracting, at least to the beginning of September, 1984. This section will describe the institutional changes which have marked the transition from GOSHN to CMAC.

10.2.1 California Medical Assistance Commission (CMAC)

CMAC was actually formed in January, 1983, but existed with only oversight function until GOSHN was phased out on July 1, 1983. CMAC has seven voting members: three appointed by the governor and two each by the Senate Rules Committee and the Speaker of the Assembly. Additionally, both the director of the Department of Health Services and the Director of the Department of Finance are ex-officio members.

William Guy was asked by CMAC to remain as executive director, but declined and left state government when GOSHN metamorphosized into CMAC. Several of the senior negotiators left at about the same time, mostly to enter private enterprise. CMAC named Mike Murray executive director in September of 1983. Murray was a former head of the HHS regional office and a former congressional staff member; at the time of his hiring he was running his own consulting business.

At the time of the site visit in February, 1984, it was too early to assess the effects of the change from a "czar" to a commission. At that time, no contracts had been substantially renegotiated so it was not possible to

obtain information on how the renegotiation process would be carried out or how it would compare to the initial negotiating process. About the only major policy product of the commission was its position that that there would be no net increase in Medi-Cal hospital expenditures in the 1984-85 fiscal year. This policy had apparently been supported by all the commissioners.

CMAC had also spent a considerable amount of time unscrambling technical problems about which services were or were not included in the contract. In the haste of contracting the previous fall, many mistakes were made in assembling "Appendix A" of the contract, particularly with regard to physician reimbursement.[6] When the first contracts were being negotiated, these appendices were purely descriptive and DHS complained that it was impossible to determine which services were or were not covered from these general descriptions. DHS worked with CMAC to change Appendix A to include a specific listing of included and excluded services by service code, including identification of which physician services were included in the hospital reimbursement. However, many of the codes in the Appendix A listings were in error because of mechanical failures or because of misunderstandings or oversights. As a result, there were 120 hospital appeals to CMAC during the state fiscal year 1983-1984 for technical changes in Appendix A, 77 of which were approved by CMAC.

At the time of the site visit, even though there was little evidence on which to base an opinion, respondents, without exception, speculated that CMAC would not be able to negotiate the second round of contracts as efficiently as GOSHN negotiated the first round. The respondents' major line of reasoning was simply that commissions have a more difficult time because they

[6]Appendix A was the portion of the contract which identified what services were or were not included in the hospital's contract.

must obtain group consensus rather than there being one individual able to make immediate decisions on an issue. Respondents also pointed out that the large number of commissioners made them more accessible to special interest group pressure. Finally, there was a strong opinion that because many of the commissioners had been appointed for their political background rather than their health care experience, that it was likely that the CMAC would be more susceptible to political pressures, direct or indirect.[7]

Follow-up telephone interviews during the first six months of its existence suggests that CMAC, at least for the time being, has avoided these pressures and indecisions. CMAC has given its staff specific marching orders--no net increase--and has not interfered in the negotiation process. One hospital respondent said: "CMAC has been completely invisible during this process, except of course for the initial policy." Another said: "CMAC has apparently defined its role very narrowly and shown no inclination to negotiate or soften that stance." It will be interesting to see how the commission responds to the increased political pressures which will accompany the final rate negotiations with LAC hospitals and with the state university hospitals.

10.2.2 Relations with Dukemejian Administration

CMAC is generally seen as a legislatively dominated commission because four of its members were named by legislative leadership; and as a Democratic commission, because all of its members were appointed by Democrats. The fact that Jerry Brown had appointed the three gubernatorial members in his last few days in office particularly upset the Dukemejian adminis-

[7]Two of the commissioners, including Richard T. Silberman, CMAC Chairman, had held key posts in the Brown administration. A third commissioner, John Burton, was a former legislator and California Congressman.

tration which consistently referred to those commission members as "midnight appointments." These factors contribute to a certain tension between the administration and CMAC, as does the administration's general feeling that contracting belongs in an executive agency because DHS is ultimately responsible for the expenditure of those funds.

Respondents generally felt that the executive-legislative split was a more important concern than the Republican-Democrat split, in part because the administration would eventually appoint its own members to the three gubernatorial seats. (Terms of two of the three commissioners appointed by outgoing Governor Brown will expire early in 1985; the Dukemejian administration will appoint new commissioners to four year terms.) Respondents also pointed out that the composition of CMAC was determined before the Republican administration was elected into office.

Another source of potential friction between CMAC and the administration is that AB 799 gives CMAC, in addition to its responsibilities on hospital contracting, authority to directly negotiate with county governments to develop capitation agreements for Medi-Cal recipients. The administration sees this authority as competition to its own program to put a substantial percentage of the Medi-Cal population under capitation agreements. There is also competition between CMAC and the administration as to where control for capitation contracting with entities other than counties would ultimately be vested. That issue, as much as anything else, delayed passage of capitation bills in the spring of 1983.

There is no reason to believe, however, that this tension causes any serious operational problems. The only clear manifestation of the problem was a dispute between the governor's office and CMAC about salary ranges for personnel. In the spring of 1983, it was determined that because of the

specific wording of the California constitution that the only way CMAC staff could be exempted from the California civil service provisions--as required by AB 799--was by defining CMAC as a part of the governor's office. Consequently, the governor's office had considerable say in CMAC hiring practices. CMAC staff suggested that part of the delay in hiring staff to replace the negotiators who left when GOSHN became CMAC stemmed from working out a compromise with the governor's office on salary ranges.

CMAC defines full staffing as seven negotiators (one of whom is the Supervising Negotiator), and six other professionals (including the executive director, the director of research and the general counsel). For almost all of fiscal 1983-1984, CMAC staff consisted of only four negotiators, four other professionals and one additional student intern. Names for two additional negotiators were submitted to the Governor's Office in August after salary ranges were settled, but were not approved. The Fiscal Year 1985 budget is about $1.5 million and assumes full staffing.[8]

One reason for the administration's general accommodation with CMAC is that CMAC's no net increase policy allowed the administration to budget no increase for contracting Medi-Cal hospitals during Fiscal Year 1984-1985. It is not clear whether that budget decision was made by the administration or invited by CMAC. In any event, one of the key issues in negotiating the third round of contracts, in 1985, will be the amount of money written into the budget for contract hospital rate increases during the budget presented in early 1985.

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[8]This includes the salaries for the seven commissioners, about $220,000.

10.2.3 Relations with DHS

As discussed in Chapter Four, relations between GOSHN and DHS had become somewhat strained during the original contracting process. One of CMAC's first priorities was to improve the operating relationship. The fact that the Medi-Cal director sits as an ex-officio member of CMAC probably helps in that endeavor. In addition, several changes designed to better integrate DHS were made in operating procedures. As CMAC adopted formal procedures for approving new contracts, they lengthened the entire review process. This gave DHS the opportunity to participate in CMAC's management review and to review proposed changes in contracts before they were submitted to CMAC for approval.[9] DHS, in turn, has streamlined contracting functions by moving some of the responsibilities that the legal department had previously handled into the office of Medi-Cal Operations where the Hospital Contracts Coordination Unit was established. The net effect, according to state respondents, was that day to day relationships were going much more smoothly.

One remaining area of DHS contracting responsibility that is unresolved concerns the role of continuing cost reporting and financial audits. Historically, the cost reports and audits were an intrinsic part of the reimbursement process because of the necessity for cost settlements. Under contracting, however, reimbursement is completely prospective and subsequent cost reports and audits are not necessary for the basic reimbursement process. Consequently, there is some hospital sentiment for discontinuing these reports.

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[9]CMAC initially extended the review process for DHS from five days to ten days, but DHS still found that insufficient and petitioned CMAC to extend their review to fifteen days. However, after some further discussions, it was determined to leave the DHS review period at ten working days.

Discontinuing the reports and audits, however, is linked to two other operational issues -- services outside contracting and third party liability recovery. Services outside contracting are those services in hospitals (almost exclusively psychiatric services) which are not covered by the hospital contract. Presumably these services will continue to be cost settled, but the state has not fully articulated the reimbursement approach to be used for non-contracting services. Third party liability recoveries relate to recoveries made when some other payer has full or partial financial responsibility for services to a Medi-Cal recipient. Often this responsibility is not established before Medi-Cal payment has been made. Historically, third party liabilities which had not been accounted for at the initial payment, were factored into the cost settlement. GOSHN apparently tried to put more responsibility on the hospitals for collecting these liabilities during the first round of contracting, but neither CMAC nor DHS feels that approach fully addressed the problem. Determination of how to handle third party liabilities must be tied to a determination of whether audits will continue and, if so, under what circumstances. Additionally, most DHS respondents felt that reporting and at least some auditing should be continued for three reasons: (1) to implement the peer group limitation for non-contract hospitals; (2) to provide an ongoing data base for reimbursing contract hospitals which terminate; and (3) to provide a reliable source of cost data in the future.[10]

Despite the improved relationship between DHS and CMAC, several respondents -- including some who supported the idea of separating GOSHN from DHS -- questioned the necessity of CMAC. After the first year of contracting,

[10]The usefulness of cost settlements for informational purposes would be greatly enhanced if settlements were more current. We found that about three-quarters of settlements for the year before contracting were not complete as of June, 1984.

these respondents felt, maintenance and further negotiation could and should be transferred to a special unit within DHS since DHS had to administer the contracts. From the standpoint of legislative history the origin of CMAC is unclear. The idea of an oversight committee for Medi-Cal had been around for some time. In 1982 a bill advocated by the California Medical Association creating such a commission was passed by the legislature but died when Governor Brown vetoed it. Apparently there was sentiment in the Senate during the negotiations over AB 799 that the addition of such a commission would make the measure somewhat more palatible to the medical interest groups. The Assembly, in the interests of getting contracting, accepted the provision. In any event, there is nothing about the legislative history which suggests that the idea of a commission was ever seen as a crucial element of the contracting process.

The main argument in favor of maintaining a separate commission outside DHS is that it provides special oversight for a process which, given its secrecy, is subject to potential abuses. Some respondents also suggested that if contracting functions were turned over to DHS, they would not be able to recruit and retain the kind of people needed as negotiators.

Arguments against having a separate commission are that it is administratively cumbersome, duplicative, and expensive. But, if its functions were turned over to DHS, for the most part, DHS would have to hire additional staff to replace CMAC staff; thus, there would be minimal savings in direct labor. The savings would be generated by eliminating the salaries of the commissioners. Considering there are seven commissioners who receive $30,000 annually this amount is material, but is still relatively minor considering the size of the overall program.

10.3 Future Issues

With few exceptions, respondents indicated that the contracting program had worked satisfactorily in the first year: that is, it produced significant savings without creating access or apparent quality of care problems. However, there was some skepticism about the impact of contracting in the longer run. This section will consider two issues which have future implications for contracting the growing concentration of Medi-Cal patients in fewer hospitals and the possibility of capitation programs.

10.3.1 Concentration of Medi-Cal Patients

Over time, Medi-Cal contracting has the potential to increase the concentration of Medi-Cal recipients in a small number of hospitals. Private sector initiatives would exacerbate the concentration. In order to work, contracting must threaten to push hospitals out of the program. And for the threat to remain credible, it must be periodically exercised. Thus, almost by definition, there will be fewer hospitals treating Medi-Cal patients under contracting than otherwise. To the extent that these are hospitals with low Medi-Cal occupancy, the impact on Medi-Cal concentration is not great. But when a large Medi-Cal provider no longer participates, this can have a great effect on surrounding hospitals. Moreover, given hospitals' concerns about having too many Medi-Cal recipients, a major termination could cause a domino effect among surrounding hospitals who would be tempted to terminate because of Medi-Cal swamping. (This has not happened yet because of the CMAC's strategy to increase the number of hospitals with Medi-Cal contracts.)

More generally, it should be remembered that Medi-Cal is the least attractive payer in the entire health care industry. The reasons are multiple: Medi-Cal conducts more audits and is more intrusive than any other

payer; Medi-Cal imposes upon doctors more than any other payer; Medi-Cal is more likely to make retroactive adjustments and more likely to change program guidelines, causing administrative confusion and, often, surprising disallowances of costs. All of the above are true not simply of Medi-Cal but of all Medicaid programs. Additionally, Medi-Cal has a utilization review program infinitely more stringent than any other California payer and requires an open staff as a condition of contract participation. All of these factors discourage hospitals from participating in the Medi-Cal program. As one hospital administrator (in a hospital which did not seek a Medi-Cal contract) put it:

> Even before contracting, Medi-Cal paid the lowest price of any payer and required the most administrative effort of any payer. I am glad to be rid of it.

Factors such as these may have had a major bearing on some hospitals' ambivalence towards pursuing Medi-Cal contracts. Despite these factors, 70 percent of the hospitals were awarded contracts.

Another factor which might contribute to an increasing concentration of Medi-Cal patients is the effect of hospital contracting by private insurance companies and other entities. First, hospitals which do not have Medi-Cal contracts can better afford to offer discounts to other payers. As one respondent put it: "I can't sell services to all payers at marginal costs." Second, there is evidence that at least some organizations seeking to sign contracts with hospitals explicitly take into consideration the amount of Medi-Cal served by the hospital. Two of the four insurance companies we interviewed had explicit criteria concerning the degree of Medi-Cal participation which would generally exclude a hospital from receiving a contract. For one company the limit was 10 percent; for the other it was 12 percent. A third insurance company in our sample used other factors which have the indir-

ect effect of excluding high Medi-Cal hospitals.

Two reasons were advanced for excluding such hospitals. One was the probability of being burdened with a portion of Medi-Cal's costs. The second was that preferred provider agreements focus on hospitals which can be readily marketed to private payers, otherwise the plan will not sell well. Private payers generally prefer hospitals with fewer Medi-Cal recipients. This may be a function of direct factors (e.g., aversion to Medi-Cal recipients) or indirect factors (e.g., hospitals with large percentages of Medi-Cal patients may have less attractive physical plants because low Medi-Cal rates have created capital shortages). Regardless of the cause, the likelihood is that there will be fewer PPO agreements with hospitals serving large percentages of Medi-Cal patients.

10.3.2 An Example from One Area

The responses of five hospitals in one of the areas we visited illustrate the possible problems:

> Hospital A has a relatively large Medi-Cal share, over 20 percent. It has been extremely successful, however, in contracting with private payers and, despite its large Medi-Cal share, gave serious consideration to not contracting with Medi-Cal. According to its CEO, their long range plan is to greatly reduce their reliance on Medi-Cal:
>
> > We feel it is our responsibility to take some Medi-Cal patients but we will not allow ourselves to be in a position where we cannot negotiate evenly with Medi-Cal.
>
> Hospital B, which is only a few blocks away, submitted a bid to Medi-Cal but was not awarded a contract. It's previous Medi-Cal revenue had been very small, only about two percent of its revenue. They claimed they did not miss Medi-Cal revenues and had no current intention of contracting.
>
> Hospital C, which is also in the same neighborhood, was also historically a low Medi-Cal provider. However Hospital C sought and received a contract. But their commitment to the contract is waivering. According to officials at Hospital C, the Medi-Cal revenues were not necessary for the hospital's survival and, though it wanted

to continue to provide some Medi-Cal services, it was unsure of how far its commitment would continue. Hospital C was also concerned about the impact Medi-Cal had on its physicians. Many attending physicians felt strongly that utilization review was unfair and that Medi-Cal physician rates were punitively low. These physicians were exerting some pressure on the hospital administration to discontinue the Medi-Cal contract. Hospital C had also experienced difficulties obtaining specialists for Medi-Cal patients once they were admitted. An official of Hospital C recounted a recent incident involving a Medi-Cal recipient admitted by a family practitioner. The physician determined that the patient needed to be seen by a neurosurgeon. However, no neurosurgeon on the hospital's staff wanted to see a Medi-Cal patient. Naturally the hospital was quite concerned and the chief of staff had to rely on personal acquaintances to find a neurosurgeon willing to become involved. The respondent summarized that the combination of physician reluctance and the low Medi-Cal rate could become a substantial deterrent to continue contracting.

Hospital D had a large share of Medi-Cal recipients and this share had grown since the advent of contracting. Medi-Cal and Medicare together now accounted for more than seventy-five percent of their volume. This hospital felt it was at a serious disadvantage in seeking other contracts. Hospital D's CFO said: "We have lots of bids out, but the only one who wants to buy our services is the government." He further lamented that negotiations with one of the major contracting insurers in the area had ended when the insurer told hospital personnel:

> We like you. We like your philosophy. Your prices are competitive. But our patients don't like your plant.

Additionally, Hospital D had recently lost a contract to Hospital E which it had formerly held for providing certain services to a local HMO.

Hospital E was not a contract hospital. It had recently won, as mentioned above, the contract for providing services to a local HMO. At present, it has no plans for seeking a Medi-Cal contract. Medi-Cal recipients had historically accounted for six to eight percent of their business.

This example illustrates some of the financial, physician and PPO factors leading to a potential increase in the concentration of Medi-Cal recipients into certain hospitals. Whether this trend will be of major importance in unclear. At least for the time being, CMAC's strategy of contracting

with more, rather than fewer, hospitals has prevented any serious problems. But the desire to both keep rates down and a large number of hospitals in the program might not work indefinitely.

On the other hand, it is uncertain if the increasing concentration of Medi-Cal recipients in hospitals really makes any difference in the quality of care available to Medi-Cal recipients. But the above example does suggest that California has set in motion dynamics which risk a greater concentration of Medi-Cal recipients than previously existed.[11]

10.3.3 Contracting and Capitation Programs

State officials, in both the executive branch and the legislature, feel that the final solution to containing Medi-Cal costs is contracting for total health packages. This solution is referred to as the "capitation" approach for Medi-Cal. The "capitation" is a single monthly payment by the state to cover all the health care needs of an enrolled individual. If capitation programs become widespread, hospital contracting will not be a significant issue because payments for hospital services will have been covered as part of the capitation payment. Until that happens, hospital contracting is merely an interim solution. As Richard Silberman, Chairman of CMAC, put it: "We are just a great big cork in the leak of a ship." He speculated that within three or four years CMAC would no longer be needed to negotiate hospital contracts because capitation programs would be the predominant mode of reimbursing for Medi-Cal services.

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[11] Many hospital respondents suggested that increasing segregation of Medi-Cal and other poor patients in county hospitals was a more "realistic" policy than trying to achieve mainstream medicine for everyone.

If Silberman and other officials are correct, the future implications of contracting may not be important. As a base for moving to a capitation program, hospital contracting is neither any better nor any worse than other reimbursement approaches. The particular hospital contracting program which the state has enacted may cause some difficulties for moving to capitation programs because contracting was so successful in reducing the base of Medi-Cal expenditures. Since the state will probably be unwilling to enter into a program which costs more than current programs, any decrease in the Medi-Cal base reduces the amount which the state would be willing to put into a capitation payment. This makes capitation programs that much less lucrative for potential providers and may, correspondingly, make it more difficult for the state to find potential bidders.[12]

If capitation does not happen quickly, the long run implications of contracting may be of some importance. And it may be some time before capitation is widespread. In the spring of 1983, supporters were confident that it could be done very quickly. By the summer of 1984, that confidence had greatly diminished. For the second year in a row, major capitation bills died in the legislature. Even the strongest legislative supporters were admitting that the time table was going to be delayed further than originally anticipated. Critics suggested even longer time horizons. Consequently, it could be four or five years before a significant portion of the Medi-Cal program was covered by capitation programs -- a long enough time period for hospital contracting to effect major changes in the delivery system. By the same token, it is unclear how widespread capitation coverage will become for

[12]This was apparently a contributing factor in the failure of a capitation bill in 1984. The legislature was concerned as to whether it could attract high quality providers for capitation programs at the current rates.

the Medi-Cal population. While supporters contend it will be very widespread (respondents suggested 80 percent of recipients) no one has any valid basis for an estimation. It is possible that the eventual percentage of recipients covered under capitation will be much lower and Medi-Cal will still have a substantial need for an independent method of reimbursing hospitals.

It is also unclear how hospital services will be included in capitation programs where the capitation program is not run by a hospital. Capitation programs could experience great difficulty living within the terms of a Medi-Cal capitation if they have to pay hospitals at rates greater than the Medi-Cal rates which generated the historical experience on which the capitation amounts were calculated. If individual capitation programs have to bargain with hospitals to get those rates, they might be at a significant disadvantage because they would not have the same leverage which the Medi-Cal program has. Thus, it is possible that the state will have to continue its own negotiation with hospitals to determine the rates which hospitals will charge to capitation programs.[13] Consideration for the future implications of contracting is warranted.

[13]Discussion at the August 15, 1984 CMAC meeting (public portion) about capitation made it clear that this issue was a point of concern both to CMAC and to several entities giving testimony about how they thought capitation might unfold.

CHAPTER 11

CONCLUSIONS

The nature of the particular analysis contained in this report does not lend itself to straightforward conclusions. We have not restricted ourselves to a quantitative analysis set from which we offer objective conclusions subject to replicability. Nevertheless, generalizations can be drawn from the data, available literature, and our interviews with the 125 or so people to whom we spoke. This chapter summarizes the key points presented in the previous chapters about the contracting program, and, in particular, discusses their implications for other states.

Does hospital contracting work in California?

It appears so. There was unquestionably a substantial savings in hospital expenditures vis-a-vis the previous system. Moreover, the savings have been accomplished with a minimal amount of public outcry, hospital dissatisfaction, or litigation. Nor is there any obvious indication of systematic harm to patients as a result of this program.

It should be pointed out, however, that the apparent success of the contracting program is, at this point, a short-run success. It is not clear how well contracting will hold up over time. In particular, the impact on patients has not been fully explored and, when we analyze patient-level data in the next report, we will examine the effects of contracting on patients.

Still, in terms of what is available at this time, contracting appears to have been successful in California.

Why was contracting successful in California?

The main reason that contracting was successful is that it is a very

powerful rate-setting approach. Medi-Cal, as the second largest individual payer in California, possesses considerable market leverage.

Beyond that, there were probably four factors which were critical to California's success:

* The legislature's willingness to grant extraordinary powers to the contracting agency;
* The state's good fortune to choose a program administrator who was willing and able to fully exploit those powers;
* The surplus of hospital beds and physicians in California which made the implied threats of contracting quite credible; and,
* The existence of California's utilization review system which controls procedures and length of stay.

The most important of the extraordinary powers granted to the contracting agency did not have to do with secrecy, its extra-agency status, or its exemption from civil service, although these probably all contributed. The most important power was its ability to be outside the normal checks and balances of adminsitrative procedure. The entire thrust of current bureaucracy is to circumscribe the discretion of the administrator. In creating GOSHN, however, the legislature gave GOSHN the power to make its own rules regarding contracting. This permitted contracting to be implemented at a speed few people believed possible. It also permitted GOSHN to tailor contracts and settlements for individual hospitals which never would have been possible in an agency operating under normal administrative procedure. This flexibility allowed GOSHN to vary the mixture of threats and concessions according to how seriously it wanted the hospital rather than according to some universally applicable regulation.

The second major factor was the state's appointment of Bill Guy. It is unlikely that Guy was the only person who could have implemented contracting. But, by the same token, it would be a mistake to undervalue his indivi-

dual contribution. The success of California contracting lies in the first HFPA that was negotiated, in San Francisco. Without San Francisco unfolding as it did, it is hard to imagine contracting achieving both the degree of savings and the degree of participation. The situation required an individual who could make the choices in San Francisco which would send the right message to hospitals in the rest of the state without creating political chaos.

The success of the program was also a function of DHS, the administering agency. The implementation of contracting was dependent on DHS' support in reviewing the contracts and their development of the management monitoring system. Without these systems in place, the contracting program would not have been implemented as smoothly as it had been.

Finally, the surplus of hospital beds and physicians was important because without that surplus, hospitals would not feel the same pressure to protect their Medi-Cal share. In high occupancy situations, hospitals would be more inclined to gamble on not having a Medi-Cal contract.

Would contracting work in other states?

While there is no empirical answer, we believe contracting could work in most states--if they really had the political fortitude for it. California adopted contracting in the midst of a serious budget crisis creating an extremely desperate need for a solution to Medi-Cal expenditures. Contracting might not have been undertaken in less of a crisis atmosphere. There are many reasons why an approach like contracting is not likely to be the strategy of legislative choice: It gives away much control of the program; it is a clear retreat from the notion of "mainstream" access;

it runs the risk of great disruption in the Medicaid program; and it creates the possibilities of clear winners and losers. Even a fairly stringent rate-setting program avoids most of the above problems.

But the logic of contracting is powerful. There are large, and not well explained, variations in the cost of providing hospital services across hospitals. There are also variations which are understood, but which have been allowed to stand for a variety of reasons not related to the provision of medical services itself (e.g., the high cost of routine services in teaching institutions). If a state is willing to face these issues, there are clearly possible savings, particularly if a state is willing to use the full advantage of its market position.

What about the four factors referenced with regard to California? In most states, at least in the more populous regions, there are sufficient excess beds to allow contracting to pose a credible threat. Certainly there are individuals capable of running such programs, although it would seem that finding an individual of the particular capabilities of a Bill Guy entails some degree of luck. And, granting extraordinary powers is clearly within a legislature's purview. Moreover, even without giving a contracting agency all the leeway which GOSHN had, it would probably be possible to run a successful contracting program. However, to the degree that these elements are not present in a state, the potential success of the contracting program would be less certain. In other words, it is unlikely that many contracting programs will enjoy the same degree of success as California.

In that respect, the experience in Illinois is illustrative. Illinois is the only other state to adopt hospital contracting. They used a much stricter bid process to solicit bids for services from hospitals and operated under administrative rules. The original solicitation was made in

the fall of 1982. When bids were received, the majority of the bids would have led to increases in expenditures rather than decreases. It took more than another year of bargaining and discussion before the first contract was signed in August, 1984, with four Chicago hospitals. The resulting contracts cover only a tiny fraction of the state's hospital population. Nevertheless, Illinois feels it has made some progress and in the summer of 1984, legislation was enacted allowing more extensive contracting. In sum, contracting can be an important weapon in a state's cost containment arsenal, but without a major commitment from the state, it is unlikely to show the dramatic savings found in California.

What are the potential pitfalls of contracting?

Decreasing access to health care for recipients is the most obvious potential problem, but at least in the short run, California has avoided that problem by awarding contracts to a large percentage of institutions. For reasons discussed earlier, other states may not be able to award contracts to as large a percentage of important Medicaid providers and still meet target savings. Major relocation of Medicaid patients will create administrative and political problems much more severe than those encountered in California.

Increasing segregation of Medicaid recipients in certain hospitals is another potential problem. How large a problem is unclear. Certainly it raises philosophical questions, and it may raise questions about quality of care--although there is no convincing evidence that quality of care is actually worse in county hospitals and other hospitals with significant Medicaid concentrations. There may, however, be tactical questions if other payers--either by design (HMOs or PPOs) or by demographics and patient choice --reduce their presence in hospitals with Medicaid concentrations. Not only might

these hospitals experience financial problems, but, in turn, the situation will greatly reduce options to negotiate for additional savings from these facilities. Should it come to pass that Medicaid patients are concentrated in a small number of facilities, contracting will merely become a peculiar form of rate-setting for those facilities. (This is probably already the case in California's county facilities where, for the most part, failure to award a Medi-Cal contract would be tantamount to closing them. Recall both first and second year negotiations surrounding the Los Angeles County hospital contract.)

The question of uncompensated care will also become a systemwide issue if contracting is used not only by Medicaid but by private payers as well. Everyone will be using market leverage to reduce their contribution to uncompensated care while the indigent will have no leverage.

These potential problems are, at the least, some distance off and, like any hypothesized problems, may never appear. The experience in California suggests it is possible to use contracting to substantially reduce costs without falling victim to these problems.

Can alternatives to contracting achieve the same results?

There are no obvious reasons why similar savings could not be achieved through other methods. An across-the-board rate reduction would seemingly achieve the same results. But, historically, states have not been able to achieve major rate reductions in their programs. In part, this is because they are restrained by litigation, and in part, because legislatures have been unwilling to make such draconian cuts directly. Hence, it may be

that in political terms there are few alternatives likely to achieve such immediate and substantial results as contracting.[1]

There are additional considerations related to alternative approaches. First, California envisions contracting for hospital services as only an interim step to contracting for all services on some kind of capitation basis. Other states, with less of an immediate fiscal crisis than that faced by California in 1982, may find it makes more sense to attempt to move directly into capitation programs. A capitation program is theoretically preferable since it places responsibility for both cost and utilization with the provider rather than requiring continual state intervention to control utilization. Remember, California has a very stringent utilization review program--with prior authorization for every admission and concurrent review on a day-by-day basis by the state. During this report we have deliberately separated the savings of contracting from the savings of the utilization review program. The savings from this utilization review program, however, are very large. Moreover, the existence of this program added a great deal of flexibility to the contracting process. States which had the political and administrative fortitude for a California-style utilization review could certainly reap substantial savings, with or without contracting. And such utilization review is necessary if contracting is based on per diems as in California.

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[1]By way of contrast, consider what happened to California's attempt to add a peer group limitation to its previous reimbursement system. Those changes were first proposed in the fall of 1981. By the spring of 1982, regulations were adopted and necessary changes made in the Medicaid state plan. However, litigation restrained attempts to implement this program until early 1984. Administrative problems and appeals resulted in savings of $30 to $40 million less than predicted in fiscal year 1984.

Is contracting a "competitive" approach?

In a sense this is an academic question. If contracting is as successful as it appears, what label is attached is of little importance. On the other hand, labels and rhetoric are an important part of decisions made in the public arena and it is therefore necessary to address this issue.

At the beginning of contracting, Alain Enthoven said of contracting: "I don't know how to call this, but don't call it competition."[2] Why not? The contract format does create some competition among hospitals because of the competition for patients: with declining volumes, most hospitals cannot afford to withdraw from the Medi-Cal program and consequently accept rate reductions. In fact, some hospitals outside the program were willing to offer even lower rates to participate in the program. CMAC, for instance, would have gone to much greater lengths to keep Merritt-Peralta Hospital in Oakland from terminating if it had not been able to get a lower rate from Providence Hospital which is virtually across the street. CMAC staff also claim that there were several other HFPAs in which hospitals were threatening to terminate but changed their mind when they found out that CMAC had sufficient capacity to easily absorb any dislocated patients. Five hospitals even accepted rate reductions when faced with the fact that CMAC was willing to initiate termination procedures without the reduction. This is a different approach from rate-setting which assumes that all hospitals will continue in the program and that the rate of any one hospital is not directly related to the response of other hospitals.

Nevertheless, there is one missing element which would make this approach clearly a "competitive" approach -- the relationship between volume

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[2]As quoted by Leonard Aucoin and Leonard Duhl, "The 1982 Health Care Reform: A Case Study in Policy Analysis," Western Center for Health Planning, San Francisco, California, 1983, p. 15.

and price. There is no serious attempt, as has been stressed throughout this report, to redirect patients to lower cost hospitals. Winning a contract does not guarantee a hospital will get any new patients, or even retain its old patients. Under the current approach, every hospital could have received a contract -- a situation almost identical to rate-setting. At best, hospitals are hoping to avoid losing the Medi-Cal patients they already have.

Medi-Cal patients have no incentives to choose one hospital over another. It is unclear whether there is any reasonably efficient and equitable manner of giving Medicaid patients such incentives short of cashing out all or part of the benefits. When, or if, a state legislature will be willing to take this step is uncertain. Equally uncertain is how the federal government would react to such an initiative. Perhaps, however, there are other approaches which the state could take to create a closer link between contracting and volume. The most obvious step would be to contract with many fewer hospitals so that contracting had a clear effect on volume. Much more difficult, but perhaps possible, would be to contract for specific volumes with hospitals where the contracted volume was related to the price.

But given the large number of hospitals with which the state has contracted, however, the conceptual difference between contracting and rate-setting approaches is greatly muted. The largest difference is that under contracting the rate is individually negotiated rather than determined by some formula.[3] As pointed out earlier, there are clear advantages to this "negotiated rate-setting" over more conventional rate-setting approaches precisely because it allows greater flexibility in individual cases. Foregone, however,

[3] Even that distinction is somewhat blurred in practice since almost all rate-setting programs allow some room for individual appeals in which formula-driven rates can be tailored to individual circumstances. Of course, the latitude for appeals varies widely among programs.

is the ability to use the public arena of rate-setting to address certain broader social policy issues--such as the distribution of access to care or the distribution of costs for uncompensated care. This is apparently not, on balance, a concern to California. And it may well not be a concern to other states. But it is an issue.

ATTACHMENT A

PROTOCOL

ATTACHMENT A

Interview Protocols

Hospital Visit Protocol

I. Check background information--mostly ownership and beds

II. BIDDING

1. Distribution of revenues and days of service by type of payer in 1982 and 1983.

2. How important was Medi-Cal to your hospital? Why was it important--covered marginal costs, community service, teaching, etc.

3. Why did you bid (not bid) for Medi-Cal?

4. Were you trying to protect existing Medi-Cal business or were you hoping to expand Medi-Cal?

5. Who was involved in developing your bid? Did you involve your accountants? Lawyers? Other external consultants?

6. How far ahead did you start planning for your bid?

7. Did you undertake quantitative modeling? How extensive? What data were used? How did you control for other changes in the environment--such as MIA transfers, changes in medical necessity, changes in volume because of contracting?

8. Did you have a good idea of your historical price? Cost? How do you think about Medi-Cal marginal costs?

9. How did you factor in the potential responses of other hospitals with whom you "compete"?

10. Did you think you were a high, medium or low cost hospital for Medi-Cal?

11. How did your historical data compare with that of the State--when discussing possible bids?

12. When you presented your bid at the second meeting, what response did you receive? How did you react?

13. Were there further negotiations by phone or in person after your written submissions?

14. Do you believe that you were competing with the absolute bid levels of other hospitals or that GOSHN was trying to achieve a given percentage decrease from you?

15. Did Medi-Cal accept your first bid? Did they give you parameters for a new bid? How did any subsequent bid prices relate to the first bid?

16. How did your final bid price relate to the previous year's rates?

17. What services were excluded in the first year bid (e.g., hospital based physicals, third party liability, mental health, neonatal, services that your hospital doesn't provide)?

18. How do you feel about basing contracting on a per diem basis? For instance, would you prefer a DRG system like the Medicare system for Medi-Cal?

19. How do you feel about the first round of bidding? From a financial viewpoint, how did you do? Are you better off than you would have been if you did not (did) get a contract?

20. Did contracting have indirect effects on revenue from changing physician patterns--e.g., physicians took other payers with them, or brought new patients, or etc.

21. Did you have a price renegotiation clause in your contract? Have you requested a renegotiation with the state? What do you plan and what do you think their response will be?

22. As you look at the past year, rank the factors of Medi-Cal changes in regard to their importance on your hospital's fiscal status:

    ____ MIA Transfer

    ____ Contracting

    ____ Changes in Medical Necessity

23. What has been the overall impact of all of the above factors on your Medi-Cal volume?

24. What do you see in the immediate future for your Medi-Cal rate? Medi-Cal participation?

Financial Implementation

25. Have you had problems getting paid for transfers--or just in working out finances of transfers?

26. For non-contracting hospitals, have you had any trouble getting paid for emergency services?

III. IMPLEMENTATION

A. Change in the definition of medical necessity:

1. What do you think the state was trying to accomplish by changing the definition of medical necessity?

2. Did the medical necessity program, as carried out by submitting TAR's (Treatment Authorization Requests), accomplish this goal?

3. Were you originally given a clear understanding of how the medical necessity program would work? Did the procedures make sense? Was the program carried out well by the state?

4. What were the major problems at first? How have they been resolved?

5. What sort of adaptations has your hospital made because of the change in the definition of medical necessity?

6. What is your current assessment of the administration of the medical necessity program?

B. Operational Implementation of SPCP:

1. Did the state (DHS) originally communicate to you what would happen after contracting--i.e., what you would have to do if you did (did not) get a contract?

2. Was their communication adequate? If there were problems, what were they?

3. Did you originally get adequate instructions from DHS on handling transfers? If no, have you since? Do you feel that the state is on top of the transfer issue?

4. Have you experienced other problems with SPCP? If so, what are these problems? How could these shortcomings have been avoided?

C. Suggestions for improvement:

1. Do you have any suggestions about how to improve the administrative aspects of the medical necessity program?

2. Do you have any suggestions about how to improve the administrative aspects of SPCP?

IV. <u>FINANCES AND PLANNING</u>

1. How has SPCP impacted your 1983 Medi-Cal revenues? Can you separate out the effects of other Medi-Cal changes (e.g., MIA's, medical necessity)?

2. How have hospital charges changed in 1983? In 1984?

3. How have hospital costs changed in 1983? In 1984?

4. How are hospital charges and costs influenced by Medicare DRG's? Are there other factors that have influenced hospital charges and costs (i.e., HMO's, PPO's, input costs, Blue Cross)?

5. What has been the impact of these factors (expressed in #4) on uncompensated care -- bad debt and charity care?

6. What has been the impact of these factors (expressed in #4) on access to debt capital?

7. Does this hospital have contracts with other payers? How have PPO's affected your hospital finances? Have PPO's been a protection against cost-shifting from the state? Do you have new marketing strategies to get your hospital involved with PPO's? Who are your primary competitors?

8. What do you think will be the long-run effect of the SPCP and the medical necessity changes on hospitals? Where do you think hospital financing is going?

V. HOSPITAL ORGANIZATION

A. What organizational and procedural changes have been made to accomodate Medi-Cal changes -- contracting and medical necessity?

1. Transfer procedures (to transfer/receive)
2. Admission procedures
3. Emergency Room procedures
4. Medical records
5. Other departments?

B. What changes have been made to better manage costs in the last two years?

1. LOS monitoring (either direction)?
2. DRG monitoring (and resulting actions regarding physician profiles or action with regard to physicians, etc.)?
3. Controls on ancillary usage?
4. Changes in nursing practices?
5. Changes in budgeting procedures?
6. Changes in supply ordering or usage?
7. Other changes?

C. What changes have been made in the hospital's relationship with physicians?

1. Have you had problems with physicians leaving because of the changes in Medi-Cal? Or with additional attendings coming in because of the changes in Medi-Cal?

2. Have you had problems with physicians following the medical necessity guidelines (i.e., submitting TAR's, following TAR

procedures)? Have physicians made appropriate adaptations to medical necessity guidelines or have they found ways of getting around the guidelines?

3. What steps has the hospital taken to make sure that physicians understand the hospital's needs and that the physicians respond to these needs?

VI. IMPACT ON PATIENTS

1. Has SPCP affected patient treatment or access to medical care during the first year? In the second year?

2. Has Medi-Cal case mix changed over the first year? Second year? Have degrees of severity within case types changed? (Any hard evidence to support it?) If there have been changes, have they been due to SPCP, changes in the medical necessity, or other changes (i.e., demographic changes)?

3. What changes have been observed in the number of Medi-Cal admissions? Medi-Cal length of stay: Medi-Cal ancillary usage (during the first year)?

4. Have you experienced greater difficulty in making referrals for services that your hospital does not provide? Or for transferring patients?

5. Have you analyzed patient satisfaction questionnaires? What do they tell you about patient satisfaction?

6. Can you document any serious adverse consequences of the SPCP?

Field Office Visit Protocol

1. What were the main problems for the first year?

2. Did you get sufficient information from the central DHS on:

   a. Changes in medical necessity?
   b. Contracting?

3. Have things settled down as the programs go on? What was done to make things better?

4. What problems remain? How would you recommend they be solved?

5. What were client problems at first:

   Finding services? Particularly specialized services? Getting authorizations? Working out transfers? Other?

How were you able to help these clients? Was central office able to help you?

6. Are things better for clients now that the program has been around a while? Why or why not? What has been done or should be done?

7. have you had specific hospital problems? What kind? With whom?

8. Do you believe that the incident reporting and general quality monitoring procedures are sufficient to protect clients?

9. Do you think the contracting program is generally working okay?

10. The medical necessity definitional changes?

11. Do you have any recommendations either for these programs or for other states which might be interested in trying them?

ATTACHMENT B

SUMMARY OF CHA PHYSICIAN SURVEY

December 8, 1983
Volume 8, Number 5

Medi-Cal hospital contracting and reductions in benefits and eligibility have affected hospitals more than doctors, but did convince physicians that drastic change is coming, according to interviews with medical staff leaders at contract and non-contract hospitals. Prior authorization is a continuing problem, and some transfers are more difficult.

Medi-Cal Contracting and Hospital Medical Staffs

by Charles H. White, Ph.D., Cindy Arstein-Kerslake and Dene McGriff

Hospital medical staffs don't like many of the Medi-Cal changes adopted by the Legislature during the 1982 state budget crisis. There is a general feeling that an era of increasing access to health care has ended. Yet nearly all physicians are resigned to the necessity of saving state money. The speed of Medi-Cal hospital contracting left many physicians in shock, but most believe the changes are only a harbinger of more drastic changes to come.

Those conclusions come from interviews this fall with chiefs of medical staffs, utilization review chairmen and emergency room directors at 14 contracting and 6 non-contracting hospitals around the state.[1] The hospitals are in all major areas where negotiations took place: Los Angeles city and suburbs, Orange County and San Diego in the south, and San Francisco, San Jose, the East Bay, Sacramento and Fresno in Northern and Central California.

How well hospitals, physicians and patients can adapt to hospital contracting and major cuts in benefits and eligibility is the unknown factor in maintaining access to quality care for Medi-Cal patients. CHA efforts to monitor the effect on hospitals have included quarterly surveys of utilization, which have shown huge declines in Medi-Cal inpatient days.[2] This study of the subjective reactions of hospital medical staffs will be followed by an examination of financial and utilization changes in both contracting and non-contracting hospitals, to be published in a future issue of *Insight*.

Hospitals chosen for the medical staff study included 12 nonprofit, 4 investor owned, 3 county and 1 district hospital. Most are large facilities: 10 have more than 400 beds; 7 have between 200 and 399 beds; only three have less than 200 beds. Because Medi-Cal has historically been concentrated in relatively few hospitals, those chosen included some formerly high-Medi-Cal hospitals that did not receive contracts, as well as some that did.

The interviews were conducted by physician consultants, with assistance from CHA staff. Those interviewed were promised anonymity; their comments were usually candid and informative, and sometimes forceful or even caustic. At least the leadership of almost all the medical staffs was involved to some extent in the contracting process, although there was general recognition that negotiations were primarily administration's responsibility. Except in county facilities where bids were public,

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few medical staff leaders and practically no attending physicians were familiar with specific contract terms or prices.

The physicians interviewed thought contracting had affected hospitals more than doctors. Most were unconcerned about Medi-Cal contracting with physicians, at least on a personal level; Medi-Cal is a smaller portion of physician than hospital income, particularly for established physicians who make up most medical staff leadership. In most of the hospitals, only a few physicians handle most Medi-Cal patients.

There were differences in attitude toward hospital contracting in some hospitals among various specialties: pediatricians, obstetricians and gynecologists wanted contracts, while orthopedists and surgeons did not. Most medical staffs at hospitals with teaching programs or with an historical commitment to the poor also wanted their hospitals to win contracts. Physicians at teaching hospitals did not want to lose the range of teaching subjects among Medi-Cal patients, which they see as essential to preparing new physicians.

Some physicians... thought contracting was a great opportunity to get out from under Medi-Cal's billing and treatment authorization hassles, as well as its low payment schedule.

Some physicians, however, thought contracting was a great opportunity to get out from under Medi-Cal's billing and treatment authorization hassles, as well as its low payment schedule. One called the lack of a Medi-Cal contract "a great boon to the private practice of medicine." Others feared contracting could damage a hospital's reputation and lead to 1960s-style "Medi-Cal mills," with the exodus of private patients speeded by ever-worsening cost shifts from Medi-Cal.

Where contracts were not offered to previously high volume Medi-Cal providers, radical changes have taken place, including heavy layoffs and deactivation of entire units. Though disappointing at first, the loss of Medi-Cal is increasingly seen as beneficial due to more stable, better-paying patients. Physicians also feel those hospitals are now in a better position to control costs, enabling them to compete more effectively for private sector contracts.

Significant shifts in medical staff were rare in either contracting or non-contracting hospitals. Most physicians have privileges at several facilities, and usually practice at the hospital they and their patients prefer. Nearly all the hospitals have open staffs, as well as provisions for interim admitting privileges.

The physicians interviewed were unanimous in seeing hospitals as increasingly economy-minded, and they felt Medi-Cal contracting reinforced the need to cut costs. At some hospitals, physicians thought that either contract or non-contract status was used as a convenient excuse for cost-cutting measures. Although some complain that cuts have led to lower nurse/patient ratios and higher liability risks, most physicians accept personnel reductions or constraints on tests as proper responses to lower revenues. No one reported any attempt to restrict usual services to Medi-Cal patients.

Individual hospitals have taken a variety of cost-cutting approaches, including constraints on tests of questionable value, elimination of "day-before" admissions for surgery, and widespread use of educational programs at department levels, particularly for house staff in teaching facilities. In most cases physicians believe that administration has borne the brunt of the cuts, and there is no feeling that quality of care has been sacrificed.

One area of concern is the movement by many hospitals to develop profiles of physician practice patterns. In general, physicians believe such profiles should be used only as an educational tool in the context of utilization review through medical staff peer review channels, and should not be used to punish physicians or control medical practice.

1. Currently, there are 245 contracting and 120 non-contracting hospitals in the 65 (of 137 in the state) Health Facilities Planning Areas where the program is in effect.

2. See CHA Insight, *Volume 7, Numbers 5, 16 and 27, and Volume 8, Number 3.*

The new "medical necessity" regulations are a sore point in some hospitals, but not in others. Questions about Treatment Authorization Requests (TARs) provoked much vehemence and hostility. Dealing with the TAR system is not a new problem, but it has been exacerbated by Medi-Cal's new definition of medical necessity and expanded requirements for prior treatment approval. The physicians generally see the Medi-Cal TAR system as, at best, a nuisance and, at worst, interference in medical practice.

Most complaints about TARs come from hospitals served by San Francisco Bay Area Medi-Cal field offices, and, to a lesser extent, the San Diego field office. There were numerous complaints about inconsistency of interpretation, delays in processing, and inaction on appeals. Especially grating to physicians was nurse on-site reviewers countermanding verbal approvals by field office physicians. Several chiefs of staff saw this as nurses practicing medicine.

The physicians charge that field office staff are not accountable for their decisions. Nothing is in writing, and staff refuse to identify themselves by phone. Criteria for denials are unclear, and the reviewers are always right since everything is open to interpretation.

In contrast, physicians in Los Angeles and Orange counties reported fewer problems obtaining TARs, and much less friction between physicians and on-site reviewers. The large Los Angeles County hospital system, which treats most Medi-Cal patients, until recently had a waiver from state TAR requirements, and its own utilization review process apparently operated more predictably. Some physicians said obtaining TAR approvals is not a great problem in the South, just a hassle to complete the time-consuming chain of necessary paperwork.

Most physicians' biggest objection was the way the system interferes with medical judgement. One doctor feels we will end up like Great Britain: "If you're poor, you are going to have a difficult time. If you have End Stage Renal Disease, you either buy your own machine or put your affairs in order."

Although some complain that cuts have led to lower nurse/patient ratios and higher liability risks, most physicians accept personnel reductions or constraints on tests as proper responses to lower revenues. No one reported any attempt to restrict usual services to Medi-Cal patients.

It seems to be too soon to tell the long term effects of the new definition of medical necessity. The physicians were split. Some thought those "ripping off" the system were being weeded out. But others tended to believe Medi-Cal beneficiaries are postponing care, and that a reservoir of more acute problems is building for the future.

Physicians in contracting hospitals did see a general trend toward a higher proportion of severely ill patients, particularly in county and teaching hospitals. County hospitals reported very high occupancy rates, more ICU days, more admissions from the Emergency Room and higher activity because more serious cases are being referred. One county hospital utilization review committee chairman said workloads are up 15 to 20 percent, with no increase in resources or staffing.

The other major area where problems were anticipated, patient transfers, was something of a surprise. Most hospitals reported little difficulty, if only because doctors and hospital staff were making a bad system work. Transfers are usually handled by physician to physician contacts or by emergency rooms. Although a transfer might be a health risk or at least an inconvenience to the patient, almost all the physicians felt patients were being properly stabilized before transfer.

Problems do occur in transferring patients from outpatient clinics of non-

The swift implementation of Medi-Cal contracting brought home the reality of drastic changes. If physicians take a laissez-faire attitude toward Medi-Cal hospital contracting, they have an opposite view of private contracts.

contract hospitals to contract facilities. If those patients need hospitalization, several hours may pass before a physician can be found to admit the patient. Sometimes the only recourse is to redirect a patient to the contract hospital's emergency room.

In Los Angeles, nearly every physician interviewed said that the county hospitals have functioned as a safety valve. But occupancy in county facilities has been running above capacity, and there can be long waits after admission until a bed is available. With the exception of transfers to county hospitals, physicians reported very few transfers between contracting hospitals.

There are also some service shortages that complicate transfers in the Los Angeles area: Few local hospitals or doctors accept patients needing obstetric, pediatric or orthopedic care. All orthopedics and most obstetrics cases go to county facilities.

In general, staff physicians sympathize with the financial problems of hospitals, and with the need to limit consumption of hospital resources. They agree that some doctors need to change wasteful patterns of practice, but want that controlled by the medical staff, rather than the state or hospitals. Working against change in wasteful patterns is the disproportionately high risk of malpractice litigation from treating Medi-Cal patients, which promotes "defensive" medicine.

Medi-Cal contracting is not nearly so important to physicians as the changes coming from Medicare and private insurors. For most, Medi-Cal is more trouble than it is worth. Many older, established physicians drop Medi-Cal as their practices expand, leaving it to physicians just starting out. Medi-Cal physician contracting is thus not an issue; physicians don't trust the state, nor do they need Medi-Cal to survive.

The prospect of private sector contracting is another matter. The swift implementation of Medi-Cal contracting brought home the reality of drastic changes. If physicians take a laissez-faire attitude toward Medi-Cal hospital contracting, they have an opposite view of private contracts.

Most medical staffs are actively organizing to be ready when the time comes, creating independent practice associations, preferred provider organizations, and other separate, but often parallel, corporate bodies.

Some physicians see their hospitals as amazingly reluctant to start new programs or actively market ambulatory services for fear of alienating the medical staff. But other hospitals have expanded outpatient services in hopes of replacing revenues lost from inpatient services, or are starting or joining PPOs to market their services to business and private insurors. Meanwhile, physicians have been more active and imaginative than expected.

If nothing else, the sudden onset of contract negotiations promoted serious discussions of the future of health care among physicians and administrators—in some cases a monumental accomplishment in itself. The improved communications and mutual understanding of problems may help both through the critical years ahead.

ATTACHMENT C

REGULATIONS IMPLEMENTING CHANGE IN DEFINITION

OF MEDICAL NECESSITY

COMPUTER SCIENCES CORPORATION GOVERNMENT HEALTH SERVICES

MEDI-CAL UPDATE

P.O. BOX 15080, SACRAMENTO, CA 95813

MEDICAL SERVICES BULLETIN NO. 50 **AUGUST 1982**

Prior Authorization Required for Procedures Generally Considered to be Elective

Medi-Cal coverage of certain health care services will be reduced to include only those services considered medically necessary to protect life or prevent significant disability. This policy applies to services rendered on or after September 1, 1982 and results from recent state legislation (Welfare and Institutions Code, Section 14133.3) and Title 22, California Administrative Code, Section 51303 (a).

The procedures listed in "List I: Procedures Generally Considered to be Elective" will be subject to intense scrutiny by the Medi-Cal Field Office and must meet criteria established by the Department of Health Services as shown in List II. All procedures on List I will be covered by Medi-Cal only if medical necessity is established in accordance with the above standard by thorough documentation and if prior authorization is obtained from a field office medical consultant. The procedures noted by an "X" are only to be performed on an outpatient basis. The services for anesthesiology and assistant surgeons do not require prior authorization.

If any of the listed procedures are performed on an emergency basis, providers must submit a Treatment Authorization Request (TAR) to the Medi-Cal field office after performing the emergency procedure. When submitting Treatment Authorization Requests for emergency services, the provider must include documentation that the procedure was medically necessary in accordance with the new standard and justification that an emergency condition existed.

Please refer to page 2-29 of your provider manual for instructions on completing the Treatment Authorization Request (TAR) form (50-1). Completed TARs must be submitted to the appropriate Medi-Cal Field Office for approval. A list of the Medi-Cal Field offices is contained in Appendix E of your provider manual.

(Continued)

LIST I. PROCEDURES GENERALLY CONSIDERED TO BE ELECTIVE

	10000-10003	I&D, sebaceous cyst
	11100-11101	Skin biopsy
	15920	Coccygectomy
	15922	Coccygectomy
	15930	Excision, sacral decubitus ulcer
	15932	Excision, sacral decubitus ulcer
	15940	Excision, ischial decubitus ulcer
	15942	Excision, ischial decubitus ulcer
	15944	Excision, ischial decubitus ulcer
	15950	Excision, trochanteric decubitus ulcer
	15952	Excision, trochanteric decubitus ulcer
	15954	Excision, trochanteric decubitus ulcer
	19140-19141	Mastectomy for gynecomastia
	20260	Ostectomy (bone spur, benign tumor)
	20268	Ostectomy (bone spur, benign tumor)
	21200	Osteoplasty of mandible
	21201-21202	Bone graft, facial bone
	21210	Bone graft, facial bone
	21215	Bone graft, mandible
	21220	Chin implant
	21230	Cartilage graft
	21235	Cartilage graft
x	21700	Division, scalenus anticus
	21705	Division, scalenus anticus
	21720	Division, sternocleidomastoid
	21725	Division, sternocleidomastoid
	21740-21741	Pectus excavatum
x	23000	Removal, subdeltoid calcium
	28090	Excision, lesion of tendon or fibrous sheath, foot or toe
	28290	Bunionectomy
	28292-28294	Bunionectomy
	28296	Bunionectomy
	28298	Bunionectomy
	30124	Excision, dermoid cyst, nose
x	30125	Excision, dermoid cyst, nose
	30210	Proetz therapy
	30500	SMR, septum
	30540	Repair, choanal artesia
	30545	Repair, choanal artesia
	30580	Repair, oromaxillary fistula
	30600	Repair, oronasal fistula
	36460	Intrauterine fetal transfusion
	39541	Repair diaphragmatic hernia
	42840-42841	T&A
	42850	T&A

x Outpatient procedure

66840	Cataract removal
66850	Cataract removal
66915	Cataract removal
66920	Cataract removal
66930	Cataract removal
66940	Cataract removal
66945	Cataract removal
67311-67313	Strabismus surgery
67320	Strabismus surgery
67331-67332	Strabismus surgery
67916-67917	Blepharoplasty
67923-67924	Blepharoplasty
90761	Periodic or annual type exam, 12-17 years
90762	Periodic or annual type exam, 5-11 years
90763	Periodic or annual type exam, 1-4 years
90764	Periodic or annual type exam, <1 year
93725	Plethysmography, regional
97000	Physical medicine, office visit, 1 modality
97050	Physical medicine, office visit, 2 or more modalities
97100-97101	Physical medicine, office visit
97200-97201	Physical medicine, office visit
97220-97221	Hubbard tank
97240-97241	Pool therapy or Hubbard tank with exercise

COMPUTER SCIENCES CORPORATION — GOVERNMENT HEALTH SERVICES

MEDI-CAL UPDATE

P.O. BOX 15001, SACRAMENTO, CA 95813

MEDICAL SERVICES BULLETIN NO. 52 **AUGUST 1982**

Ambulatory Surgical Procedures: Surgical Procedures Amenable to Outpatient Performance

Medi-Cal policy requires that certain surgical procedures be performed on an ambulatory (outpatient) basis, usually in an organized outpatient clinic with surgical facilities. This policy will affect the procedures on the attached list when performed on or after September 1, 1982. Approval of a Treatment Authorization Request (TAR) for inpatient performance for these procedures will only be granted when a documented medical condition(s) exists making an ambulatory setting inappropriate, such as:

- The necessity for prolonged postoperative nursing or medical observation because of concomitant systemic disease such as diabetes or a severe heart condition
- When another nonrelated procedure requiring hospitalization is to be done on the same occasion as the "outpatient" service

A surgical procedure on the attached list may require conversion to or continuation as an inpatient service (such as a breast biopsy determined on frozen section to be malignant or a knee arthroscopy revealing necessity for meniscectomy). In these circumstances, request verbal authorization from a Medi-Cal Field Office Consultant or document justification on the Treatment Authorization Request (TAR) when verbal approval is unavailable.

The current program procedures for obtaining prior authorization for inpatient hospital services must be followed when services on the attached list are provided in an inpatient hospital setting.

Instructions for replacement pages:

Appendix C: Add new pages C-39 through C-44.

Appendix G: Insert this bulletin.

LIST OF PROCEDURES FREQUENTLY DONE IN INPATIENT SETTING TO BE DONE IN AN OUTPATIENT SURGICAL SETTING UNLESS OTHERWISE AUTHORIZED

The following surgical procedures must be performed on an ambulatory (outpatient) basis. TAR approval for inpatient performance of these procedures will only be granted when a documented medical condition exists making an outpatient setting inappropriate.

19020 -- Mastotomy with exploration, deep abscess
20525 -- Foreign body in tissue, complicated
20680 -- Removal of screws (foreign body), deep
20900 -- Bone, small graft
21040 -- Excision of mandible bone cyst
21100 -- Halo application for maxillo-facial fixation
21325 -- Open reduction of nose, uncomplicated
21330 -- Open reduction of nose, complicated
21335 -- Open reduction of nose, complicated, septum
21360 -- Malar fracture depressed, open reduction
21485 -- Temporo, mandibular reduction
21501 -- Incision codes, deep
21700 -- Scalenus Anticus, Division
22900 -- Excision subfascial abdominal tumor
23000 -- Removal subdeltoid deposits
23020 -- Capsule contracture release (Erbs)
23530 -- Closed or open clavicle fracture
24105 -- Olecranon bursa excision
24134 -- Sequestrectomy of bone abscess
24138 -- Sequestrectomy olecranon process
24139 -- Sequestrectomy olecranon process with suction
24578 -- Open repair condylar fracture
24579 -- Open repair condylar fracture with or without fixation
25000 -- Tenovaginotomy at wrist
25020 -- Fasciotomy, flexor or extensor compartment
25023 -- Fasciotomy with debridement
25035 -- Incision, deep (osteo) forearm
25075 -- Excision, forearm tumor
25085 -- Capsulectomy, wrist
25100 -- Arthrotomy for biopsy
25110 -- Excision of tendon sheath lesion
25116 -- Tenosynovectomy, forearm extensors
25117 -- Tenosynovectomy, flexors
25120 -- Excision or curettage of bone cyst
25260 -- Repair tendon, forearm
25262 -- Secondary, single tendon repair
25263 -- Each additional forearm tendon
25270 -- Repair, extensor muscle
25271 -- Each additional tendon
25272 -- Secondary, single

26390 -- Excision flexor tendon
26410 -- Extensor tendon repair, hand
26418 -- Extensor tendon repair, dorsum finger
26420 -- Extensor tendon repair, dorsum finger and graft
26421 -- Each added tendon graft
26426 -- Central slip repair, hand
26428 -- Central slip repair, hand with graft
26432 -- Mallet finger repair
26434 -- Mallet finger repair with graft
26440 -- Tenolysis, flexor tendon, palm
26441 -- Tenolysis, multiple
26443 -- Tenolysis, flexor tendon
26447 -- Tenolysis, extensor tendon
26449 -- Tenolysis, complex
26450 -- Tenotomy, flexor open palm
26451 -- Tenotomy, multiple
26455 -- Tenotomy, finger, single
26460 -- Tenotomy, extensor hand
26471 -- Tenodesis for interphalangeal joint stabilization
26474 -- Tenodesis for distal joint stabilization
26508 -- Thenar muscle release
26520 -- Capsulectomy for contracture
26525 -- Interphalangeal joint
26530 -- Arthroplasty metacarpophalangeal joint
26531 -- Arthroplasty metacarpophalangeal joint with prosthetic implant
26533 -- Arthroplasty, multiple
26535 -- Arthroplasty, interphalangeal joint
26536 -- Arthroplasty, with prosthetic implant
26538 -- Multiple with or without implant
26545 -- Reconstruction, interphalangeal joint, single
26565 -- Osteotomy for deformity
26567 -- Osteotomy, phalanx
26610 -- Open reduction metacarpal fracture
26615 -- Open reduction metacarpal
26630 -- Open reduction metacarpal with manipulation
26635 -- Open reduction without fixation
26675 -- Carpometacarpal dislocation, anesthesia
26705 -- Metacarpophalangeal dislocation with anesthesia
26730 -- Open phalangeal fracture
26760 -- Phalangeal fracture open with manipulation
26765 -- Phalangeal fracture open with manipulation without fixation
26780 -- Intra-articular phalangeal dislocation fracture without fixation
26785 -- Intra-articular phalangeal dislocation fracture, complex
26990 -- Incision, drain deep hematoma
27196 -- Closed reduction with anesthesia, sacrum
27301 -- Incise deep abscess thigh
27345 -- Excision of popliteal cyst
27372 -- Removal of foreign body from knee

50980 -- Endoscopy with removal of foreign body
51040 -- Cystotomy with drainage
51045 -- Cystotomy with insertion of ureteral catheter
51050 -- Cystolithotomy with calculus removal
51060 -- Transvesical ureterelithotomy
51065 -- Cystotomy with stone basket
51080 -- Drainage of perivesical space abscess
51500 -- Excision of urachal cyst
52100 -- Cystourethroscopy, hospital
52202 -- Cystourethroscopy with biopsy, hospital
52212 -- Cystourethroscopy with fulguration
52222 -- Cystourethroscopy with fulguration and biopsy
52235 -- Fulguration of medium bladder tumor
52260 -- Bladder dilation with anesthesia
52277 -- Cystourethroscopy with resection of sphincter
52282 -- Cystourethroscopy with steroid injection
52285 -- Cystourethroscopy with urethral syndrome
52290 -- Cystourethroscopy with urethral meatotomy
52305 -- Cystourethroscopy with resection of bladder diversion
52310 -- Cystourethroscopy with removal of foreign body
52335 -- Cystourethroscopy with ureteroscopy
52800 -- Litholapaxy
53010 -- Perineal urethra, incision
53080 -- Drain of perineal urinary extravasation
53250 -- Excision of Cowper's gland
54015 -- Incision and drainage of penis, deep
54105 -- Biopsy, deep structure penis
54115 -- Removal of foreign body, penis (implant)
54505 -- Testis biopsy
54506 -- Testis biopsy
54550 -- Undescended testis
54820 -- Epididymis spermatocele
55120 -- Removal of foreign body in scrotum
55600 -- Vesiculotomy
55650 -- Vesiculotomy unilateral or bilateral
55680 -- Excision of Mullerian duct cyst
56400 -- Incision and drainage of vulvar abscess
56740 -- Bartholin cyst excision
57130 -- Excision of vaginal septum
57200 -- Colporrhaphy
57210 -- Colpoperineorrhaphy
57220 -- Plastic urethral sphincter
57230 -- Plastic repair of urethrocele
57521 -- Trachelectomy
57525 -- Cryoconization for pre malignant
57720 -- Trachelorrhaphy
60200 -- Local excision of small cyst or isthmus transection
62289 -- Epidural or caudal puncture
63744 -- Spinal shunt
64708 -- Neurolysis

COMPUTER SCIENCES CORPORATION GOVERNMENT HEALTH SERVICES

MEDI-CAL UPDATE

P.O. BOX 1601 SACRAMENTO, CA 95813

MEDICAL SERVICES BULLETIN NO. 49 **AUGUST 1982**

Procedures Generally Excluded from Coverage

Medi-Cal coverage of designated health care services will be reduced to include only those services considered medically necessary to protect life or prevent significant disability. This policy applies to services rendered on or after September 1, 1982 and results from recent state legislation (Welfare and Institutions Code, Section 14133.3) and Title 22, California Administrative Code, Section 51303 (a).

The procedures listed in this bulletin will no longer be considered for payment by the Medi-Cal program unless the provider establishes the medical necessity for the procedure in accordance with the above standard. Services on the list that require hospitalization of the patient must be fully justified in accordance with the above standard during the prior authorization process. Claims for listed procedures that do not require hospitalization of the patient will be denied. Providers wishing to appeal denials must present sufficient documentation to fully justify the medical necessity of the procedure in accordance with the new standard on all appeals of claim denials.

New Denial Code Message

A new denial reason code has been added to the list of Explanation of Benefits (EOBs) and Remittance Advices (RAs).

145 - Procedure billed not payable on date of service billed

Instructions for replacement pages:

Appendix C: Insert new pages C-27 through C-31.

Appendix G: Insert this bulletin.

PROCEDURES GENERALLY EXCLUDED FROM COVERAGE

10040	Acne surgery
11050-11052	Paring or curetting benign lesions
11200-11201	Excision of benign skin tags
11400-11405	Excision of benign skin tags
11420-11425	Excision of benign skin tags
11440-11444	Excision of benign skin tags
11446	Excision of benign skin tags
11700-11701	Debridement of nails
11710-11711	Debridement of nails
11730-11732	Avulsion of nails
11770-11771	Excision, pilonidal cyst or sinus, simple-extensive
11900-11901	Intralesional injection
11920-11922	Tatooing
11950	Subcutaneous injection of filling material
11951	Subcutaneous injection of filling material
11952	Subcutaneous injection of filling material
11954	Subcutaneous injection of filling material
13350-13351	Dermodesis
15775	Punch graft, hair transplant
15776	Punch graft, hair transplant
15780	Abrasion of skin
15785-15787	Abrasion of skin
15790-15791	Superficial chemosurgery (skin peel)
15800	Abrasion plus chemosurgery
15810-15811	Salabrasion
15820-15822	Rhytidectomy
15824	Rhytidectomy
15826-15828	Rhytidectomy
15830	Rhytidectomy
17000-17002	Destruction of benign lesions, face
17010	Destruction of benign lesions, face
17100-17102	Destruction of benign lesions, other than face
17104-17105	Destruction of benign lesions, other than face
17110	Destruction of benign lesions, other than face
17200-17201	Electrosurgical destruction, fibro-cut tags
17360	Chemical exfoliation for acne
17380	Electrolysis epilation
19000-19001	Aspiration, breast cyst (allow 19100: needle biopsy)
19120-19121	Excision, benign breast lesion
19184-19187	Subcutaneous mastectomy with immediate or delayed implant

40806	Incision, labial frenum
40810	Excision of lesion, vestibule of mouth
40812	Excision of lesion, vestibule of mouth
40814	Excision of lesion, vestibule of mouth
40840	Vestibuloplasty, mouth
40842-40845	Vestibuloplasty, mouth
41010	Incision, lingual frenum
41520	Frenuloplasty
43885	Gastopexy for hiatal hernia
44131	Intestinal bypass for morbid obesity
46230	Hemorrhoidal tag
46900	Destruction, condylomata, anus ("complicated" allowed)
46910	Destruction, condylomata, anus ("complicated" allowed)
46920	Destruction, condylomata, anus ("complicated" allowed)
49508	Herniorrhaphy, inguinal, over age 12 years
49509	Herniorrhaphy, inguinal, over age 12 years
49510	Herniorrhaphy, inguinal, over age 12 years
49515	Herniorrhaphy, inguinal, over age 12 years
49520	Herniorrhaphy, inguinal, over age 12 years
49525	Herniorrhaphy, inguinal, over age 12 years
49579	Umbilical herniorrhaphy
49582	Umbilical herniorrhaphy
49583	Umbilical herniorrhaphy
50420	Nephropexy
53020	Meatotomy, except infants (53025, infants allowed)
53021	Meatotomy, except infants (53025, infants allowed)
54050	Destruction, condylomata, penis
54055	Destruction, condylomata, penis
54060	Destruction, condylomata, penis
54065	Destruction, condylomata, penis
54150	Newborn circumcision, clamp
54152	Other circumcision, clamp, office
54154	Other circumcision, clamp, hospital
54160	Newborn circ. surgical excision (not clamp or dorsal slit)
54161	Other circ. surgical excision (not clamp or dorsal slit)
54200-54205	Injection of penis for Peyronie's disease
54400	Insertion of penile prosthesis
54405	Insertion of penile prosthesis, inflatable
54660-54661	Insertion, testicular prosthesis
54840	Excision, spermatocele
55000	Aspiration, hydrocele

74725	X-ray of abdomen for fetal age, multiple view
75510	CO_2 angiocardiography for pericardial effusion
75550	Coronary arteriography by cineradiography
75780	Extremity arteriography without serialography
78401	Cardiac blood pool, imaging, static
83520 (69 RVS)	Icterus index
83533	Protein bound iodine
83870	Mucoprotein, blood
87300	Vaccine, autogenous
88000-88037	Autopsy
89000 (69 RVS)	Basal metabolism rate
90088	Periodic or annual type exam, adult
92310	Prescription and fitting of contact lens
92312-92314	Prescription and fitting of contact lens
92316-92317	Prescription and fitting of contact lens
92325	Modification of contact lens
93201-93207	Phonocardiogram
93220-93222	Vectorcardiogram
93240	Ballistocardiogram
93720	Plethysmography, total body
94630	Pulmonary rehabilitation
96450	Phlebotomy, therapeutic
96900	Actinotherapy
96905	Actinotherapy
96920	Galvanic iontophoresis
97260-97261	Manipulation
97750-97751	Physical therapy outside usual location of practice

ATTACHMENT D

Exhibits D.1 and D.2 display principal types of service, occupancy rates, and bed size by contract and non-contract hospitals. Exhibits D.3 through D.5 present unweighted Medi-Cal perdiems before and after contracting for all hospitals, by cohort, and by peer group, ownership status and rate type. All per diems have been deflated by the inflation factors used by the Fiscal Forecasting Division in DHS, and represent January 1983 dollars. Exhibits D.6 and D.7 display unweighted predicted and actual per diems by month (Exhibit D.6) and by cohort (Exhibit D.7). Finally, Exhibits D.8 and D.9 show the regression results used to estimate the predicted rates. Exhibit D.8 presents unweighted results. Exhibit D.9 presents the weighted results that are referred to in Chapter 6.

Methodology for Estimating the Predicted and Actual Per diems

Medi-Cal month of service hospital claims from July, 1980 to September 1983 submitted by contract hospitals were analyzed to estimate the per diems that would have been paid to contract hospitals in the absence of contracting. Specifically, per diems prior to contracting were estimated from all claims submitted prior to the contract effective date, controlling for:

- cohort;
- peer group;
- ownership status;
- principal type of service;
- monthly inflation;
- seasonal effects;

- bed size;
- occupancy rate;
- Medi-Cal length of stay; and,
- Medi--Cal discharges.

In order to estimate the predicted per diems, the coefficients resulting from this equation were applied to all the claims submitted after contract implementation.

Exhibits D.8 and D.9 present the coefficients used to estimate the predicted rates. The per diems in D.8 are not weighted, but are adjusted for inflation. In order to better reflect Medi-Cal outlays per diems in D.9 are weighted by the number of Medi-Cal general acute care patient days.

Exhibit D.1

PRINCIPAL SERVICE OF CONTRACT AND NON-CONTRACT HOSPITALS

	Contract Hospitals (n=245)		Non-Contract Hospitals (n=90)	
Principal Service	Number of Hospitals	Percent of Hospitals	Number of Hospitals	Percent of Hospitals
Med/Surg	233	95%	84	93%
Psych	3	1%	0	--%
Other[b]	9	4%	6	7%
		100%		100%

NOTE: Differences between contract and non-contract hospitals are not significant.

[b]The 'other' category includes: pediatric, rehab, respiratory, chemical dependency, chronic disability, orthopedic and other.

Exhibit D.2

LICENSED BEDS AND OCCUPANCY RATE BY CONTRACT STATUS

	Contract Hospitals (n=244)		Non-Contract Hospitals (n=88)	
	Number of Hospitals	Percent of Hospitals	Number of Hospitals	Percent of Hospitals
Bed Size				
Small (1-49 beds)	26	11%	8	9%
Moderate (50-299 beds)	163	67%	65	74%
Large (300+ beds)	55	23%	15	17%
		100%		100%
Occupancy Rate	(n=242) 60%		(n=87) 57%	

NOTE: Differences between contract and non-contract hospitals are not significant.

Exhibit D.3

MEDI-CAL PER DIEMS BEFORE AND AFTER CONTRACTING
FOR ALL HOSPITALS, CONTRACT HOSPITALS, AND NON-CONTRACT HOSPITALS[a]

	Per diems Before Contracting	Per diems After Contracting	Percent Change
All Hospitals	$587 (n=332)	$580 (n=317)	-1.2%**
Contract Hospitals	$576 (n=244)	$499 (n=242)	-13.4%**
Non-Contract Hospitals	$619 (n=88)	$905 (n=75)	+46.2%**

NOTE: **Differences between the per diems before and after contracting are significant at the .01 level.

[a]Month of service hospital claims for the twelve months prior to contracting were averaged to calculate the pre-contracting per diems. These per diems prior to contracing represent interim Medi-Cal payments before audit settlements. Claims for the first eight months under contracting (up to September 1983) were averaged to calculate the per diems after contracting. The sample sizes may differ between time periods because of the frequency of claim submissions. A few hospitals had not yet submitted a claim between the onset of contracting and September 1983. All per diems have been converted to constant dollars, as of January 1983.

Exhibit D.4

MEDI-CAL PER DIEMS BEFORE AND AFTER CONTRACTING
BY COHORT FOR CONTRACT HOSPITALS[a]

Cohort	General Area of HFPAs	Before Contracting	After Contracting	Percent Change
February[b]	Daly City Sacramento Long Beach Lynwood San Diego			
March	East Bay Santa Clara			
April	San Fernando Valley San Gabriel Valley Los Angeles La Canada San Diego North County-County	$602 (n=139)	$505 (n=138)	-16.1%**
May	Orange County			
June	Merced Modesto Central Valley Santa Cruz San Luis Obispo San Bernardino-Metro			
July	Central Valley Oxnard Lancaster Contra Costa County Riverside San Bernardino County San Diego North-City	$527 (n=91)	$475 (n=90)	-9.9%**
August	Susanville Fairfield Bakersfield Banning			
San Francisco	San Francisco	$650	$556	-14.5**

Differences between the per diems before and after contracting are significant at the .01 level.

[a]Month of service hospital claims for the twelve months prior to contracting were averaged to calculate the pre-contracting per diems. These per diems prior to contracing represent interim Medi-Cal payments before audit settlements. Claims for the first eight months under contracting (up to September 1983) were averaged to calculate the per diems after contracting. The sample sizes may differ between time periods because of the frequency of claim submissions. A few hospitals had not yet submitted a claim between the onset of contracting and September 1983. All per diems have been converted to constant dollars, as of January, 1983. These per diems are not weighted.

[b]As a result of the unique circumstances surrounding the San Francisco negotiations, San Francisco is excluded from the February cohort and given its own cohort.

[c]The figures represent the results from the renegotiations in July.

Exhibit D.5

MEDI-CAL PER DIEMS BEFORE AND AFTER CONTRACTING
BY OWNERSHIP STATUS, PEER GROUP, AND RATE TYPE FOR CONTRACT HOSPITALS[a]

	Per diems Before Contracting	Per diems After Contracting	Percent Change
Ownership Status			
Non-profit	$581 (n=115)	$507 (n=113)	-12.7%**
Proprietary	$569 (n=75)	$479 (n=75)	-15.8%**
County	$608 (n=21)	$555 (n=21)	-8.7%**
City/County/District[b]	$495 (n=27)	$439 (n=27)	-11.3%**
UC/State	$838 (n=6)	$667 (n=6)	-20.4%**
Peer Group			
University Teaching	$820 (n=8)	$644 (n=8)	-21.5%**
Non-University Teaching	$696 (n=12)	$605 (n=12)	-13.1%**
Large Complex	$591 (n=49)	$521 (n=49)	-11.8%**
Moderate-Sized	$577 (n=64)	$495 (n=64)	-14.2%**
Small Urban	$527 (n=77)	$459 (n=76)	-12.9%**
Other	$553 (n=33)	$468 (n=32)	-15.4%**
Rate Type			
All-Inclusive Per diem	$572 (n=205)	$489 (n=203)	-14.5**
Alternative Rate[c]	$594 (n=39)	$555 (n=39)	-6.6%**

**Differences between time periods are significant at the .01 level.

[a]Month of service hospital claims for the twelve months prior to contracting were averaged to calculate the pre-contracting per diems. These per diems prior to contracing represent interim Medi-Cal payments before audit settlements. Claims for the first eight months under contracting (up to September 1983) were averaged to calculate the per diems after contracting. The sample sizes may differ between time periods because of the frequency of claim submissions. A few hospitals had not yet submitted a claim between the onset of contracting and September 1983. All per diems have been converted to constant dollars, as of January 1983. These per diems are not weighted.

[b]Hospitals owned by a district or jointly owned by a county and city are included in this category.

[c]Alternative rates include rates based on timelessness of payment on the number of patient days, discharge rates, and rates for separate services.

Exhibit D.6

PREDICTED PER DIEM SAVINGS UNDER CONTRACTING
BY MONTH - FEBRUARY TO SEPTEMBER 1983[a]

Month	Predicted Per diem Payment	Actual Per diem Payment	Percent Change
February 1983	$594	$558	-6.1%
March 1983	$619	$536	-13.4%
April 1983	$632	$520	-17.7%
May 1983	$637	$524	-17.7%
June 1983	$616	$503	-18.3%
July 1983	$592	$492	-16.9%
August 1983	$621	$497	-20.0%
September 1983	$623	$494	-20.7%
Average	$617	$506	-18.0%**

NOTE: **Differences between actual and predicted per diems are significant at the .01 level.

[a]These per diems are not weighted. All per diems have been converted to constant dollars, as of January, 1983.

Exhibit D.7

PREDICTED PER DIEM SAVINGS UNDER CONTRACTING BY COHORT[a]
FEBRUARY - SEPTEMBER 1983

Cohort	General Area of HFPAs	Predicted Per diem Payment	Actual Per diem Payment	Percent Change
February[a]	Daly City Sacramento Long Beach Lynwood San Diego			
March	East Bay Santa Clara	$636	$506	-20.4%**
April	San Fernando Valley San Gabriel Valley Los Angeles La Canada San Diego North-County			
May	Orange County			
June	Merced Modesto Central Valley Santa Cruz San Luis Obispo San Bernardino-Metro			
July	Central Valley Oxnard Lancaster Contra Costa County Riverside San Bernardino County San Diego North-City	$551	$475	-13.8%
August	Susanville Fairfield Bakersfield Banning			
San Francisco	San Francisco	$659	$600	-9.0%

NOTE: **Differences between actual and predicted per diems are significant at the .01 level.

[a]These per diems are not weighted. All per diems have been converted to constant dollars, as of January, 1983.

Exhibit D.8

ESTIMATED COEFFICIENTS FOR PREDICTED AND ACTUAL PER DIEMS

Dependent Variable: Medi-Cal Per diem[a] R^2 = .32

Explanatory Variable	Estimated Coefficient
Intercept	440.19**
TREND	4.10**
Cohort-Mar	50.00**
Cohort-Apr	46.00**
Cohort-May	33.24**
Cohort-June	-80.78**
Cohort-July	-2.38
Cohort-Aug	-69.55**
Cohort-San Francisco	15.22*
Jan	15.71*
Feb	13.13*
Mar	20.39**
Apr	19.92**
May	20.63**
June	21.90**
Aug	27.55**
Sept	24.98**
Oct	17.35**
Nov	25.13**
Dec	19.65
Service-Psychiatric	-252.26**
Service-Pediatric	62.50**
Service-Rehab	-136.56**
Service-Other	73.28**
Peer-University Teaching	351.47**
Peer-Non-University Teaching	158.28**
Peer-Large Complex	49.97**
Peer-Moderate Sized	21.65**
Peer-Other	29.86**
Own-City/County/District	-52.10**
Own-Proprietary	13.23**
Own-County	38.44**
Own-UC	-87.99**
Licensed Beds	-.02
Licensed Occupancy	-4.10**
Medi-Cal Length of Stay	-.53**
GAC Medi-Cal Discharges	-.12**

Where: Intercept = a non-profit medical/surgical small urban contract hospital operating in July in state fiscal year 1980-81 and negotiated with the state in February; and,

Trend = a continuous variable starting with 0 for July 1980 and ending with 38 for September 1983.

*Significant at the .05 level.
**Significant at the .01 level.

[a]Per diems have been converted to constant dollars, as of January 1983.

Exhibit D.9

ESTIMATED COEFFICIENTS FOR PREDICTED AND ACTUAL PER DIEMS[b]

Dependent Variable: Medi-Cal Per diem[a] R^2 = .55

Explanatory Variable	Estimated Coefficient
Intercept	478.82**
TREND	5.42**
Cohort-Mar	63.51**
Cohort-Apr	43.24**
Cohort-May	5.42
Cohort-June	-73.02**
Cohort-July	-44.98**
Cohort-Aug	-62.18**
Cohort-San Francisco	-7.07
Jan	17.27*
Feb	11.52*
Mar	16.31**
Apr	15.16**
May	11.72*
June	12.84*
Aug	32.92**
Sept	26.83**
Oct	22.48**
Nov	18.06**
Dec	17.81**
Service-Psychiatric	-188.59
Service-Pediatric	98.49**
Service-Rehab	-140.13
Service-Other	81.50**
Peer-University Teaching	359.67**
Peer-Non-University Teaching	183.50**
Peer-Large Complex	69.40**
Peer-Moderate Sized	6.69
Peer-Other	1.55
Own-City/County/District	-60.26**
Own-Proprietary	6.87+
Own-County	31.17**
Own-UC	-90.76**
Licensed Beds	-.09**
Licensed Occupancy	-1.00**
Medi-Cal Length of Stay	-.76**
GAC Medi-Cal Discharges	-.06**

Where: Intercept = a non-profit medical/surgical small urban contract hosital operating in July in state fiscal year 1980-81 and negotiated with the state in February; and,

Trend = a continuous variable starting with 0 for July 1980 and ending with 38 for September 1983.

+Significant at the .10 level.
*Significant at the .05 level.
**Significant at the .01 level.

[a]Per diems have been converted to constant dollars, as of January, 1983.

[b]Per diem is weighted by the number of Medi-Cal general acute care patient days to better reflect Medi-Cal outlays.

ATTACHMENT E

Review of DHS Savings Estimation Methodology

Attachment E: Review of DHS Savings Estimation Methodology

DHS'methodology for estimating savings under contracting has been reasonably stable since the beginning of the program, although improved data has allowed for some refinement of the estimates. The following review is based on extensive discussion with the DHS forecasting staff in February, 1984, supplemented by written material in May 1984, continued telephone contact, and some calculations of our own to generally verify the DHS calculations. Additionally, our analysis of per diem rates--presented in Chapter Six--allowed for a general confirmation of the DHS savings estimates.

California's Cost Savings Methodology

DHS estimates program savings over any period say, fiscal year 1983-84, as the difference between a projection of what would have been spent under the old system and what was spent under contracting. It is important to point out that to some degree the amount of savings generated by contracting will always be an estimate because there is no way of unequivocally stating what expenditures would have been in the absence of contracting. It is only possible to make a reasonable estimate of what those expenditures would have been and then compare actual expenditures to the estimated expenditures in the absence of contracting. Of course, the longer contracting continues, the more difficult it becomes to estimate what expenditures would have been in the absence of contracting.

Moreover, in the absence of final expenditures for some contracting period, it is also necessary to estimate expenditures under contracting. Thus, since the savings estimates presented in Chapter Six were for a fiscal year not yet completed, actual contractual expenditures were estimated. At some point in the near future, it will be possible to replace the estimate

expenses under contracting with an actual expenditure. What would have been spent in the absence of contracting, however, will always be an estimate.

Exhibit E.1 contains the various equations used in making both estimates of what would have been spent (referred to by DHS as the "benchmark estimate") and estimates of actual expenditures. Equation 1 shows that in time t, savings are the differences between total benchmark expenditures (EXP^a) and estimated total expenditures under contracting as ($CREP_i$). The remainder of this section describes the estimation of each component.

Consider, first, the forecast of what expenditures would have been without contracting, the benchmark estimate (see eq. 2). This forecast is made by predicting interim expenditures in the absence of contracting ($\hat{EXP}_{kt}$) in the k-th HFPA (Health Facility Planning Area) in successive years and then adjusting for two retrospective adjustments: α = a percentage adjustment for routine post-audit disallowances (see eq. 3); and β = a percentage reduction due to either excess cost inflation or low occupancy. Interim rates are calculated as a fraction of hospital charges. However, the calculation does not precisely estimate the difference between charges and allowable costs. When settlements are made at the time of calculating rates, hospitals typically own Medi-Cal. Hence hence $\alpha<1$. This results in a downward adjustment to the benchmark. Also, beginning in July, 1980, the State began to constrain the rise in hospital costs per discharge for selected items (e.g., nursing hours). Hospitals were held to an intensity growth rate based on the Medicare National DRI (Discharge Resource Index) plus 1 percentage point; if regulated final payments per discharge exceeded this rate, the difference was also owed to the state at the time of final payments. This term has been described as β --see eqs. (4) and (5). Moreover, in October, 1981, a 55% occupancy minimum was applied to hospital fixed costs; those below

this floor had their interim rate reduced by the discrepancy weighted by the fixed cost share (see eq. 6). For example, if (FC/TC) = .4, and the hospital's actual occupancy, OCC = .50, then the occupancy penalty would be EXPOCC = 1-[(.5/.55)(.4) + .6] = .036, and predicted interim payments (EXP^1) would actually have been 3.6% higher than final payments (EXP^f).

The larger task in deriving the benchmark, however, is in projecting the hypothetical interim payments themselves, $\hat{EXP}_{kt}$ This is done through separate projections of users, U, days of care, LOS, and per diem rates, PD, at the HPFA level, stratified by contract and noncontract hospitals (see eqs. 7-10). Linear, OLS regression methods were used on two and a half years of data (July, 1980 - December, 1982) with the HPFA-month as the unit of analysis. For users and days per user, identical specifications are used (see eqs. 8-9): a 1-30 month time dummy, TIME; a seasonality dummy for each month, MN; and a single month dummy for September, 1982, when the definition of "medical necessity" was made more restrictive, NEC. The projection of payment trends (eq. 10) differs only in the substitution of the annual Medicare National DRI, prorated to a monthly basis, for the time dummy.

Thus, for each of 65 closed HPFAs, 6 regressions are run: users, days per user, and per diems by contract/noncontract hospitals in each HPFA. $\hat{D}$ is then derived as the product of predicted users and days per user for each HFPA (see eq. 11). Predictions into 1984 are generated by simply incrementing the monthly TIME dummy in eqs. 8 and 9 another 12 months. Medicare DRI forecasts of hospital market basket increases are similarly used to forecast per diems using eq. (11). Multiplying the forecasts of days by the forecasts of per diems and summing across contract and noncontract hospitals gives total predicted interim payments by HFPA (eq. 7). Exhibits E.2 and E.3 show total benchmark (i.e. predicted interim payments in the

absence of contracting) for contracting and noncontracting hospitals on a statewide basis as estimated in May, 1984.

To complete the calculation of savings estimates, α and β as calculated above are subtracted from the savings estimate. (These two variables have different values depending on whether the estimate is a date of payment estimate or a date of service estimate. In the former, their values are an estimate of what savings would have occurred in the year under question from repayments from former years. In the latter, their values are estimates of what settlements would ultimately have been made to interim rates paid for services offered in that particular year, even though those adjustments would not have been made under several years later.) Adjustments are also made for medical transportation costs, and changes in hospital based physician costs.

Prior to completion of a given fiscal year it is also necessary to estimate what the payments will be under contracting. This is done by creating a weighted sum of payments per day in contracting and noncontracting hospitals, the weights being the number of predicted Medi-Cal days in each group (see eq. 12). In the original forecasts, the number of Medi-Cal days predicted in contracting hospitals (TMD) was the sum of their own historical Medi-Cal days (reduced by MIAs and Medicare cross-overs) and a percentage of the forecasted days they are expected to pick up from noncontract hospitals (see eq. 13). Subsequently, it was possible to replace forecast days with actual days once experience under contracting was reflected in the claims data. The percentage of days routed from non-contract hospitals, λ, is less than 1.0 because of leakage, either due to emergency cases that require stabilization first, deliveries not able to reach a contracting hospital in time, or very specialized care not covered by any contracting hospital (e.g., neurosurgery). The original estimate of leakage was 24 percent, but using actual data that estimate was reduced to 14 percent.

Once total contract-hospital days in a HPFA are forecasted, the estimate is multiplied by an estimate of the average contract per day rate in the HPFA, $\overline{CPD}$, based on a weighted average of each hospital's contract rate (see eq. 14).* Originally, the weights were based on each hospital's Medi-Cal bed capacity share MB/TMB, defined as their own historical Medical days (D_i minus MIAs) plus unused bed-days, UD_i, divided by 365, then divided again by Total Medi-Cal Beds (TMB_k) in the HPFA. Contract hospitals with relatively more Medi-Cal days, historically, and/or with greater excess capacity had their contract rate weighted more heavily in the HPFA average, on the assumption that they had greater capacity to handle noncontract transfers. In savings estimates from May 1984 onward, it was possible to replace estimated utilization with actual utilization rates under contracting.

For the 14% of days that remain in non-contract institutions, they are weighted by the forecasted benchmark per diem (see eq. 13), which, as described in Chapter Six, is significantly higher than it would have been in the absence of contracting since the cases remaining at noncontracting hospitals tend to be emergency cases receiving high intensity care. The result is a total predicted program cost ($C\hat{P}D$) that covers payments to both contract and noncontract hospitals.

Exhibits E.4, E.5 and E.6 compare the estimated expenditures thus derived and the earlier derived benchmark estimates.

Future Refinements

At the time the first year forecasts were made, the state had no practical experience with contracting; hence the need to forecase ($CE\hat{X}P$)

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* Most hospitals have only a single flat rate, but some have multiple rates, requiring some within-hospital weighting first.

expenditures under contracting. Subsequent data, however, has allowed recalibration of the model. For example, in the first estimate a 24% figure was used as a measure of possible leakage in the system representing legitimate noncontract days. So far, actual leakage has been running much lower (about 14%). The revised estimates of program savings are higher as a result. As more months of data become available, separate month-year dummies will be included in the user and days regressions to capture actual usage, eliminating the need for an arbitrary leakage adjustment. That is, monthly 1984 contract and noncontract days will be adjusted upwards and downwards, respectively, for the inevitable transfer of patients to the former.

A slightly more important adjustment was a refinement in the number of base users to reflect the new definition of admissions under contracting. Contracting pays only one per diem for mothers and newborns; the previous system paid for each separately. It was therefore necessary to make an adjustment to historic days so that they were being measured on a base comparable to the one to which contract rates were applied. This resulted in a reduction in total estimated days and, as a result, a reduction in the total estimate savings. (As can be seen from the above, the a very simplified description of how contract savings are estimated is to estimate the the difference between contract and benchmark perdiems and multiply by the number of days under contracting. If estimates of the number of days under contracting are reduced, the savings estimates will likewise be reduced.) The result of this refinement was to decrease savings estimates by about $10 million before adjustments.

Critique of State's Saving Estimation Methodology

The state's methodology is basically sound. The most obviously confounding effects--the change in the definition of medical necessity and the

change in MIA treatment--have been accounted for in the analysis in the utilization estimates. The resulting estimates correctly focus on savings due to contracting per se. The basic forecasting model is a powerful trend model based on 36 months of historical data incorporating seasonal variables. Separate calculations are made for individual market areas allowing for variations around the state. Users and days per user are being projected separately, further refining the projections.

Where could the model be in error? There are several places where the model could be in error, but none of them likely to effect the order of magnitude of the savings being realized. Even if the model were off by as much as 20 per cent--and we are relatively sure it is not--the fiscal year 1983-84 date of service savings would still be more than $110 million. Nevertheless, it is worth looking at the sources of possible noise.

We have identified at least three possible problem areas:

* Utilization assumptions may turn out to be inaccurate;
* There may be some misspecification in the estimate of per diems from national DRI forecasts;
* Use of state averages for estimating final settlements may be insufficiently accurate; and

First, the model is based on assumptions about utilization trends. Although the model includes reasonable safeguards to insure that the utilization forecasts take into account predictable changes, it is possible that some random changes will affect the actual outcome. Without additional specifications in the model, these will impact the savings estimates. Moreover, our own calculations using aggregate state data--rather than predicting on an HFPA-by-HFPA basis as done by DHS--forecast a slightly lower number of contract users in subsequent fiscal years. An overestimation of the number of days under contracting would lead to an overstatement of savings.

The difference in forecast days results from problems in the estimating the impact of the change in the definition of Medical Necessity on an HFPA-by-HPFA basis. Determination of the correst forecast would be an expensive and time consuming process. But the difference between the two estimates is less than two percent and the correct forecast is, in all likelihood, somewhere between the two estimates.

In any event, respecification of the model using actual utilization data in both expenditures and benchmark can resolve all the problems about volume estimation if one is willing to assume that contracting in itself had no impact on aggregate volume. This seems like a reasonable assumption and one which, at least to this point, is supported by both our analyses and those of DHS.

Second, the estimation of benchmark assumes that the historical relationship of California hospital costs to DRI inflation estimates will continue essentially unchanged and, additionally, that errors in the DRI estimates are essentially random. Both of these assumptions, while necessary for forecasting work, are most likely in some degree of error. Respecification of the savings after all the actual rates of marketbasket inflation are known may increase or decrease the saving estimates. Since, however, new estimates for the fiscal year 1984 were prepared late in the Spring, these estimates are likely to be quite stable.

More importantly, the use regression of DRI on historical per diems probably introduces some bias because of the systematic historic divergence between DRI and historic per diems. That is, since historic per diems were increasing at a consistently steeper rate than DRI, regression of DRI on historic per diems will result in a coefficient which consistently underestimates what per diems would have been in the absence of contracting.

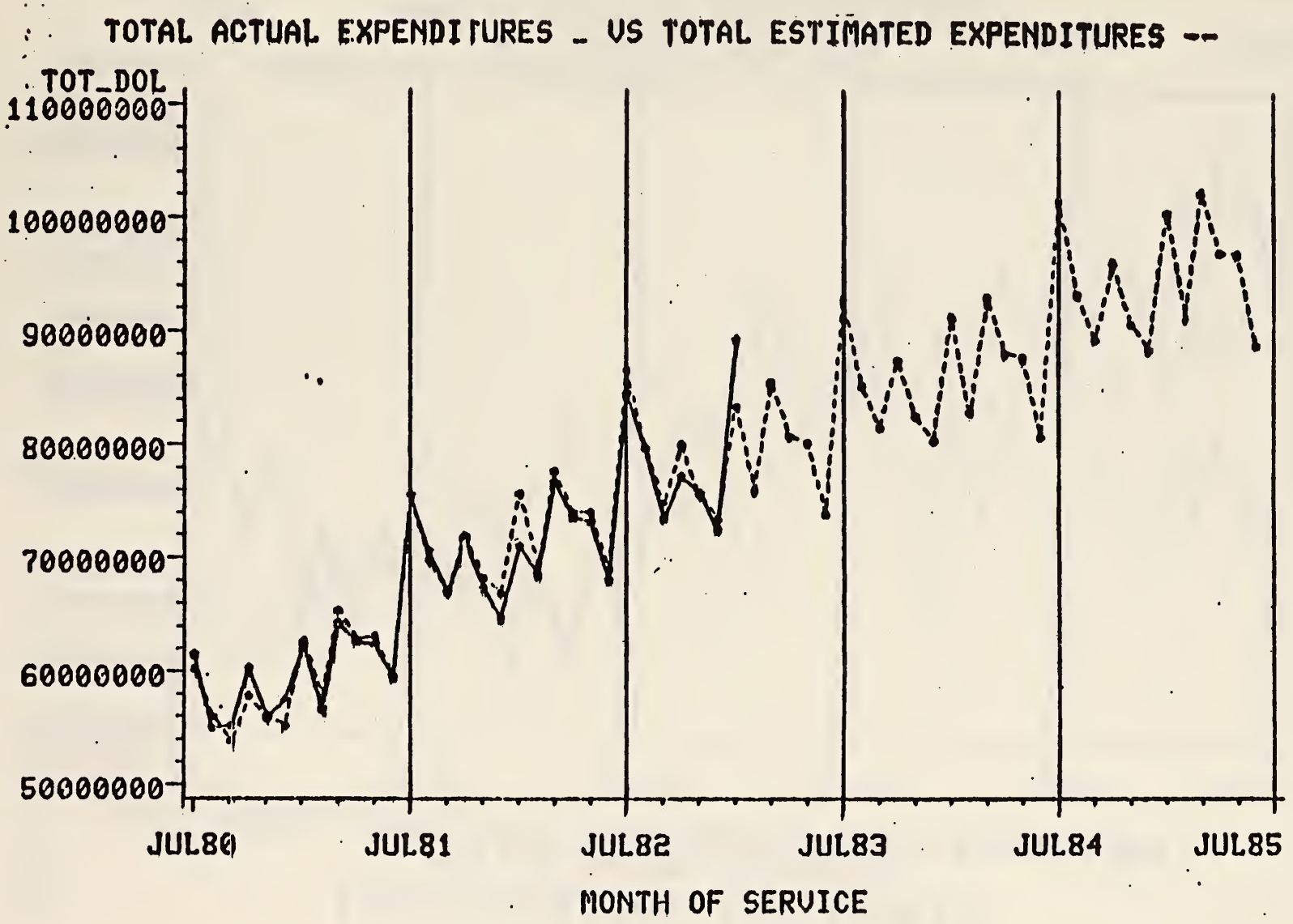
Because of this problem, as discussed in Chapter 6, we used a different approach to estimating per diems in the absence of contracting, an approach which did not directly rely on DRI forecasts. The effect of the methodology used by the state is to slightly understate savings from contracting, and therefore is less cause for concern than an error which overstates. Nevertheless, the size of the error could become significant the further contracting gets from the pre-contracting period on which the projections of per diems rest. (Unlike utilization forecasts, the addition of new data points does not give information for reestimations since it is obvious that contracting radically changes the per diem base.)

Finally, it is hard to estimate the various administrative adjustments made as part of the previous payment process. Thus, for the various settlement data used to develop the benchmark, single percentage estimates are made based on a state average although it is known there are wide variations among hospitals. Differences among specific hospitals--or among contracting and non-contracting hospitals--might bias the estimate. It would be extremely useful if the state could make final rates available on a more timely basis and minimize the amount of estimation necessary. (We found, for instance, that as of July 1, 1984 fewer than 60 hospitals' fiscal year 1982 had been settled. Thus, it was impossible to estimate savings even against 1982 final rates.

To reiterate our beginning statement, however, the methodology appears fundamentally sound and the above issues are extremely unlikely to result in a major basis in the model. What is most likely the largest problem, the handling of DRI in predicting per diems, probably results in an understatement of savings, but failure to include administrative costs and possible volume problems may result in an overstatement of savings. Thus,

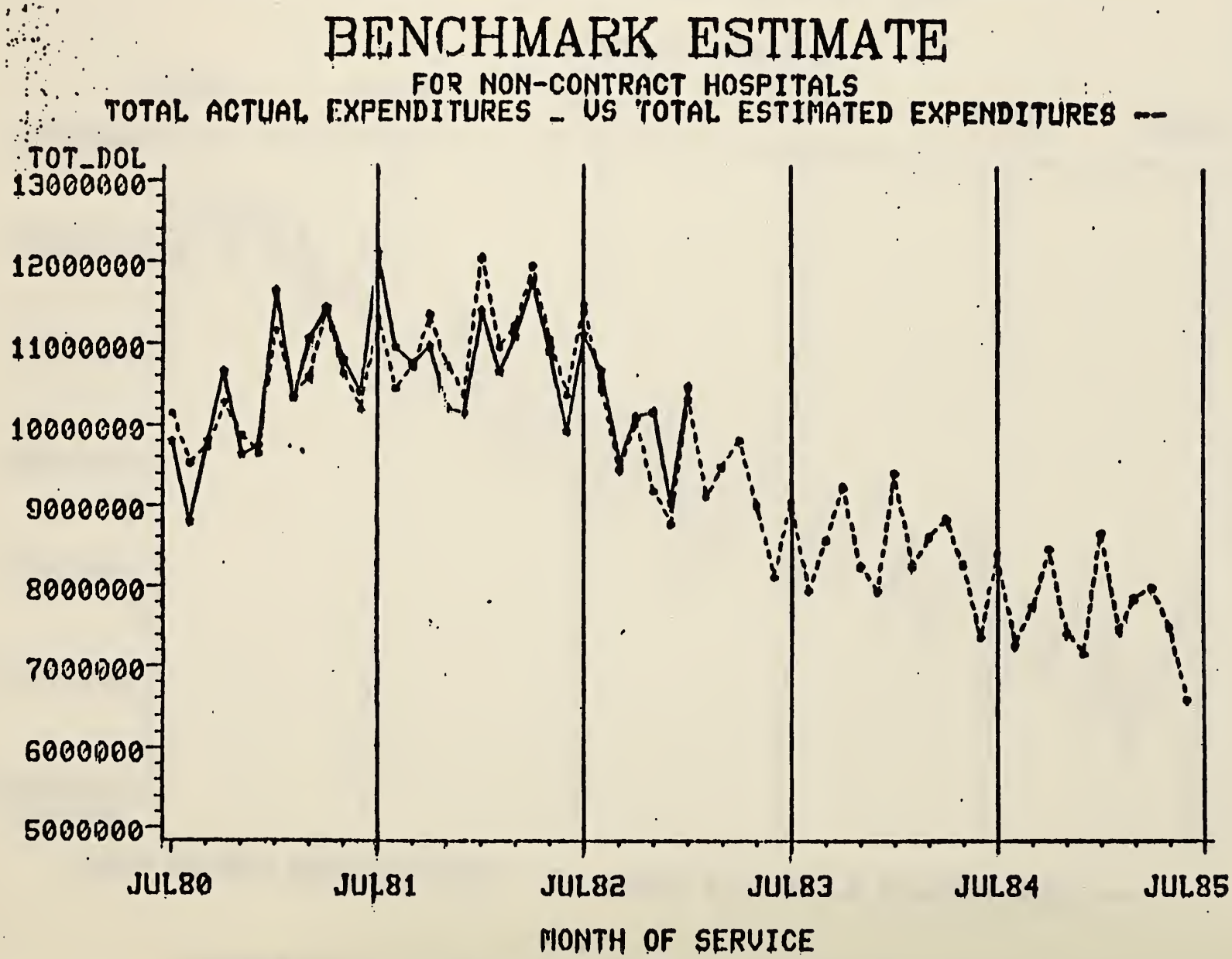
even these small issues tend to cancel themselves out and suggest the state's estimates are fundamentally sound.

Benchmark Estimate (and History) for Contract Hospital Expenditures



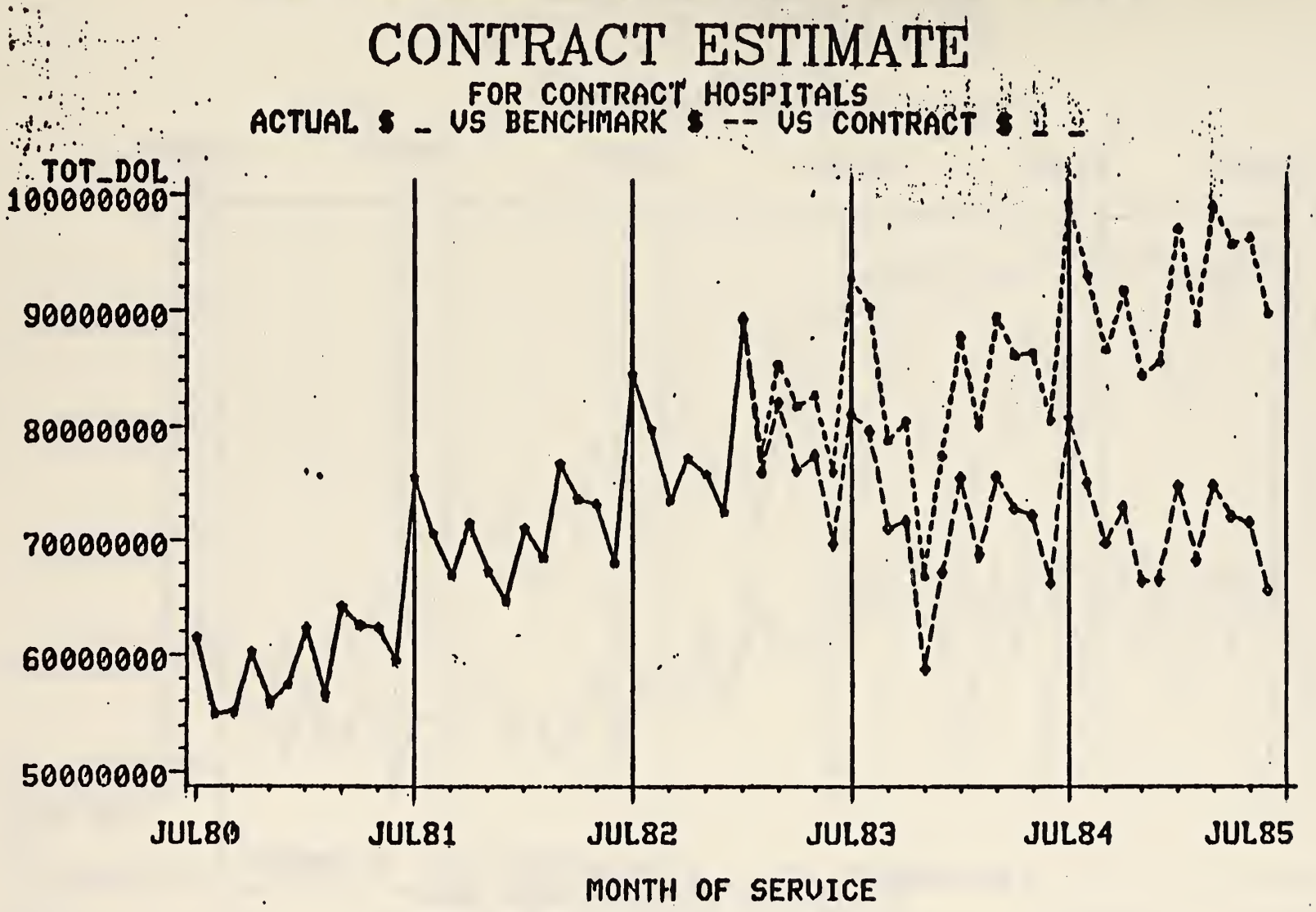
Source: California DHS, May, 1984

Benchmark Estimate (and History) for Non-Contract Hospital Expenditures



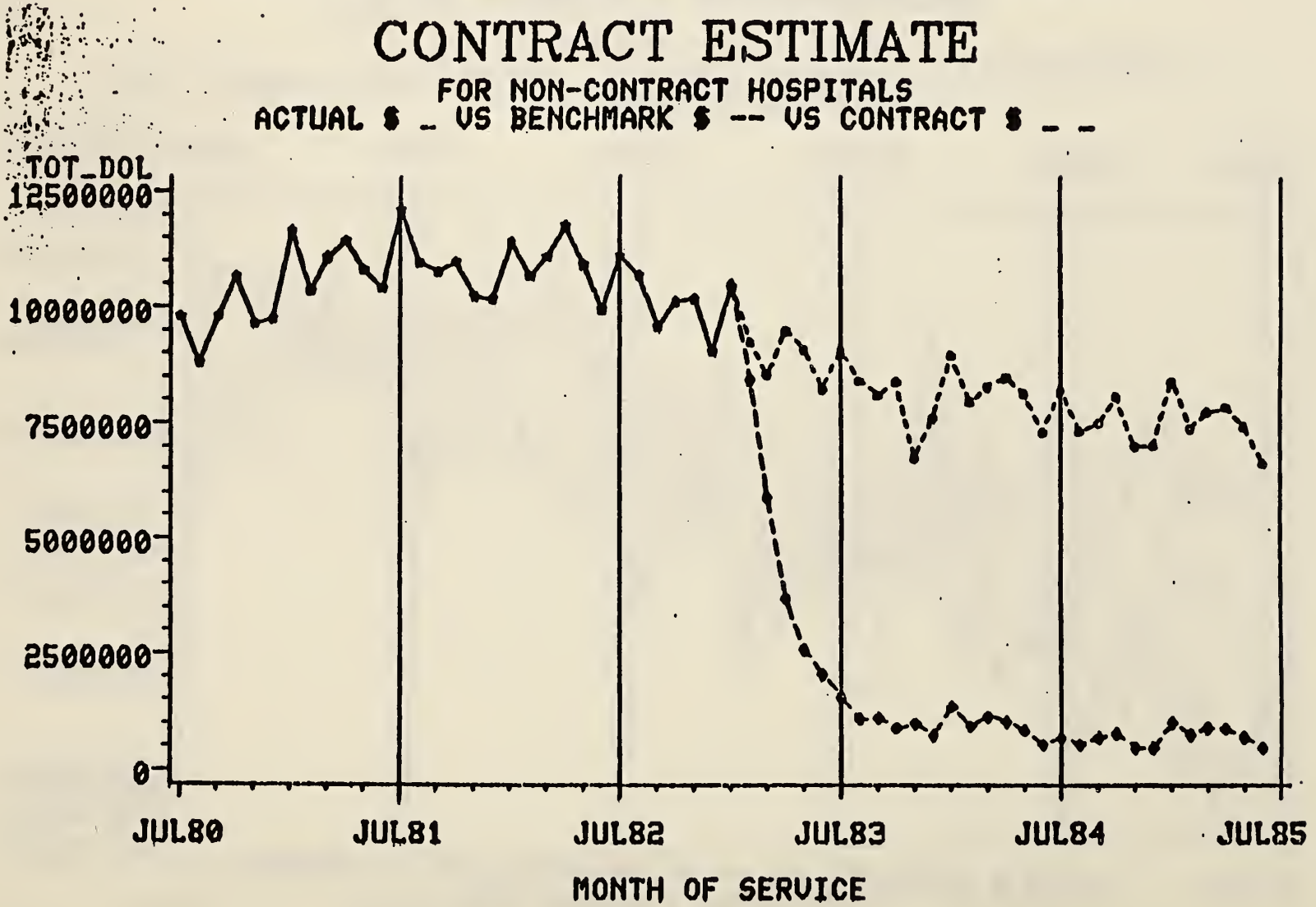
Source: California DHS, May, 1984

Actual Versus Benchmark Estimates(and History) for Contract Hospitals



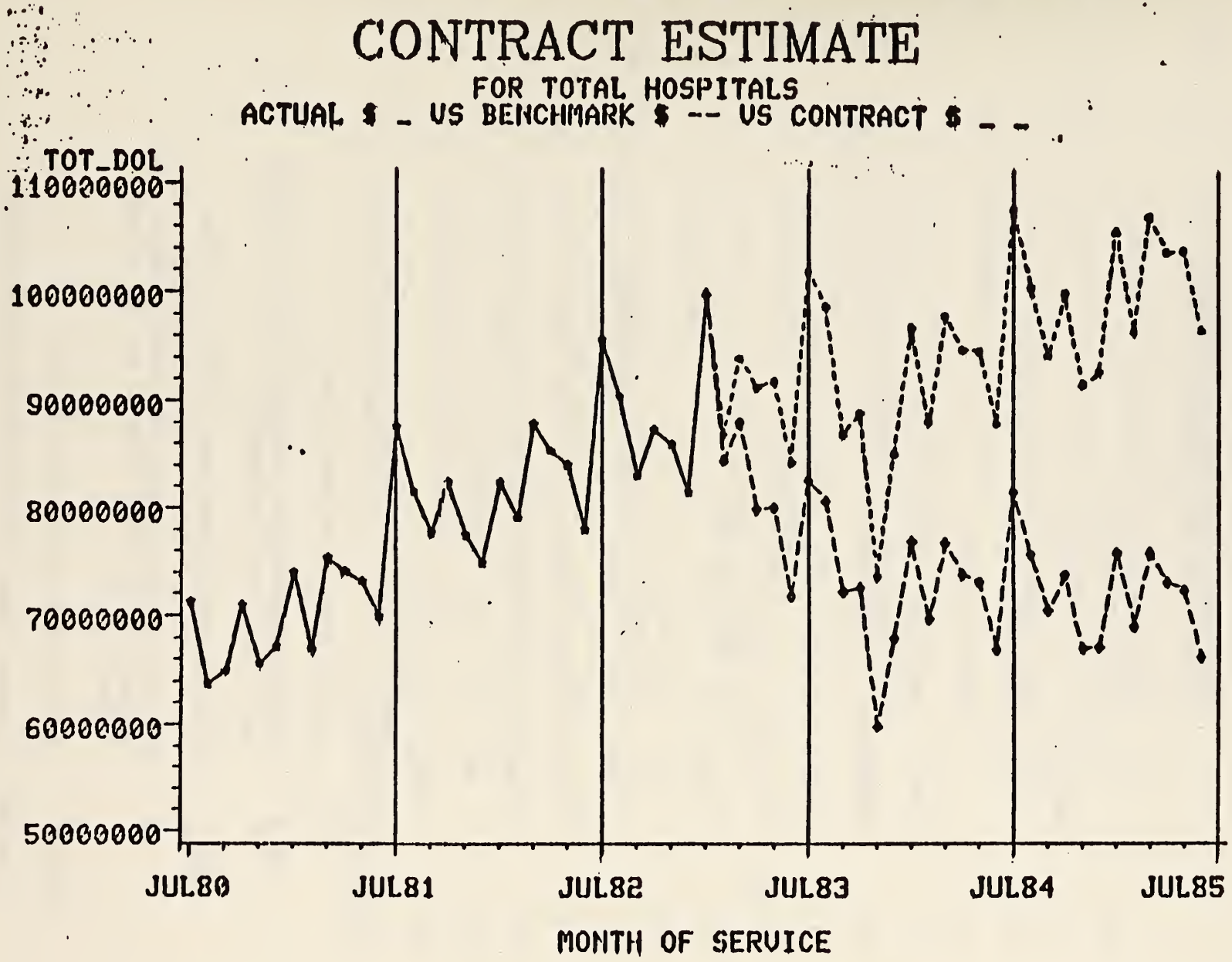
Source: California DHS, May, 1984

Actual Versus Benchmark Estimates(and History) for Non-Contract Hospitals



Source: California DHS, May, 1984

Actual Versus Benchmark Estimates(and History) for Total Hospitals



Source: California DHS, May, 1984

Exhibit E.1

EQUATIONS USED BY DHS IN ESTIMATING
BENCHMARK AND ACTUAL CONTRACT SAVINGS

$$(1) \qquad S_t^a = \sum_k (EXP_{kt}^a - CEXP_{kt})$$

$$(2) \qquad EXP_{kt}^a = (1 - \alpha - \beta)EXP_{kt}$$

$$(3) \qquad \alpha = EXP_{kt}^f / EXP_{kt}^i$$

$$(4) \qquad \beta = EXPDIS + EXPOCC$$

$$(5) \qquad EXPDIS = \%\Delta AEXPDIS - (\%\Delta DRI + 1)$$

$$(6) \qquad EXPOCC = 1 - \left| \frac{\overline{OCC}}{.55}(FC/TC) + (\overline{OC/TC}) \right|$$

$$(7) \qquad EXP_{kt} = \sum_j U_{jkt} \cdot LOS_{jkt} \cdot PD_{jkt}$$

$$(8)\text{-}(9) \qquad [U, LOS]_{jk} = f_{jk}(TIME, MN, NEC)$$

$$(10) \qquad PD_{jkt} = g_{jk}(DRI, MN, NEC)$$

$$(11) \qquad D_{jkt} = U_{jkt} LOS_{jkt}, \; j = C, N$$

$$(12) \qquad TMD_{kt} = D_{ckt} + \gamma D_{nkt}, \; \gamma = .86 \text{ (leakage rate)}$$

$$(13) \qquad CEXP_{kt} = TMD_{kt} \cdot CPD_{ckt} + (1 - \gamma)D_{nkt} PD_{nkt}$$

$$(14) \qquad CPD_{ckt} = \sum_{i \,\varepsilon\, k} (MB_i / TMB_k) \overline{CPD}_i$$

$$(15) \qquad MB_i = (D_i - MIA_i + UD_i)/365$$

$$(16) \qquad TMB_k = \sum_{i \,\varepsilon\, k} MB_i$$

Variable Definitions

s_t^a = estimated program savings in year t

EXP_{kt}^a = projected expenditures (adjusted under old program in k-th market area (the "benchmark")

$CEXP_{kt}$ = estimated expenditures under SPCP contracting

α, β = discount factors for post-audit disallowances (α); excess cost inflation (EXPDIS) and low occupancy (EXPOCC) (β)

EXP^f/EXP^i = ratio of final to interim payments

$\%\Delta$ AEXPDIS = percent change in allowable cost per discharge

$\%\Delta$ DRI = percent change in DRI price index

OCC = average occupancy rate

FC/TC, OC/TC = average fixed and other costs, respectively

$\hat{U}_{jkt}$ = predicted number of medical users in contract vs. noncontract hospitals in k-th market area

$\hat{LOS}_{jkt}$ = predicted LOS by hospital type and market area

$\hat{PD}_{jkt}$ = predicted payment rate per diem under old program

$TIME$ = 1-30 month time dummy

MN = seasonal dummy for each month

NEC = single month for September 1982 when a more stringent definition of medical necessity for admission began to be used

$\hat{D}_{jkt}$ = predicted total inpatient days

$\hat{TMD}_{kt}$ = predicted total Medi-Cal days in market area

λ = leakage rate

$\hat{D}_{ckt}$, $\hat{D}_{nkt}$ = predicted days in contract and noncontract hospitals, respectively

$\hat{CPD}_{ckt}$ = predicted cost per diem in contract hospitals

(MB_i/TMB_k) = Medi-Cal's share of bed capacity in i-th hospital in total beds (TMB) in k-th area

$\overline{CPD}_i$ = i-th hospital's actual contract rate

D_i, MIA_i, UD_i = actual historical Medi-Cal, medically indigent, and, unused bed-days, respectively in i-th hospital

ATTACHMENT F

GLOSSARY

GLOSSARY OF ABBREVIATIONS USED IN THIS REPORT

AAI..... Abt Associates, Incorporated

AHA..... American Hospital Association

CHFC..... California Health Facilities Commission

CHA..... California Hospital Association

CMA..... California Medical Association

CMAC..... California Medical Assistance Commission

CON..... Certificate of Need

CSC..... Computer Sciences Corporation (Medi-Cal fiscal intermediary)

DHS..... Department of Health Services

DRG..... Diagnosis Related Group (part of Medicare reimbursement system)

FIMD..... Fiscal Intermediary Management Division (within DHS)

GOSHN..... Governor's Office of Special Hospital Negotiations

HCCU..... Hospital Contract Coordinating Unit (within DHS)

HCFA..... Health Care Financing Administration (part of US Department of Health and Human Services responsible for administering Medicare and Medicaid)

HFPA..... Health Facilities Planning Area (subdivisions of HSAs)

HSA..... Health Systems Area (health planning areas)

LAC..... Los Angeles County (usually refers to LAC hospital system)

MIA..... Medically Indigent Adult

OBRA..... Omnibus Budget Reconciliation Act of 1981 (Federal)

PET..... Program Evaluation Team (contracting audit teams from DHS)

PPO..... Preferred Provider Organization

PPS..... Prospective Payment System (name of Medicare reimbursement system)

SFGH..... San Francisco General Hospital

SPCP..... Selective Provider Contracting Program

TAR..... Treatment Authorization Request (part of DHS utilization review)

TEFRA..... Tax Equity and Fiscal Responsibility Act of 1982 (Federal budget reconciliation

WorldCat: Selective contracting in California

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040 HEC ‡c HEC ‡d HEC
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100 1_ Koetting, Michael.
245 10 Selective contracting in California : ‡b the first year / ‡c Mike Koetting, Lois Olinger.
260 [Baltimore, Md.] : ‡b Dept. of Health and Human Services, Health Care Financing Administration, Office of Research and Demonstrations, ‡c [1984.]
300 198, [62] p. : ‡b ill. ; ‡c 28 cm.
490 1_ Working paper series
500 "Medicaid program evaluation, Cluster II, Inpatient hospital reimbursement."
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